Table 3. Common concerns about CSE

Concerns	Response
▶ CSE leads to early sexual initiation	▶ Research from around the world clearly indicates that sexuality education rarely, if ever, leads to early sexual initiation. Research has shown that CSE has either no direct impact on the age of sexual initiation, or that it actually leads to later and more responsible sexual behaviour. For more information, see *Section 4*.
▶ CSE deprives children of their 'innocence'	▶ Evidence illustrates that children and young people benefit from receiving appropriate information that is scientifically accurate, non-judgmental and age- and developmentally-appropriate, in a carefully planned process from the beginning of formal schooling. In the absence of CSE, children and young people can be vulnerable to conflicting and sometimes even damaging messages from their peers, the media or other sources. Good quality sexuality education provides complete and correct information with an emphasis on positive values and relationships. Sexuality education is about more than sex – it includes information about the body, puberty, relationships, life skills, etc.
▶ CSE goes against our culture or religion	▶ The Guidance stresses the need to engage and build support among the custodians of culture in a given community, in order to adapt the content to the local cultural context. Key stakeholders, including religious leaders, can assist programme developers and providers to engage with the key values central to the relevant religions and cultures, as people's religious beliefs will inform what they do with the knowledge they possess. The Guidance also highlights the need to reflect on and address negative social norms and harmful practices that are not in line with human rights or that increase vulnerability and risk, especially for girls and young women or other marginalized populations.
▶ It is the role of parents and the extended family to educate our young people about sexuality	▶ As the primary source of information, support and care in shaping a healthy approach to sexuality and relationships, parents and family play a fundamental role. However, through education ministries, schools and teachers, the government should support and complement the role that parents and family play by providing holistic education for all children and young people in a safe and supportive learning environment, as well as the tools and materials necessary to deliver high-quality CSE programming.
▶ Parents will object to sexuality education being taught in schools	▶ Parents play a primary role in shaping key aspects of their children's sexual identity and their sexual and social relationships. Parents' objections to CSE programmes in school are often based on fear and lack of information about CSE and its impact, as they want to be sure that messages about sexuality and SRH are rooted in the family's values system. CSE programmes are not meant to take over the role of parents, but rather are meant to work in partnership with parents, and involve and support them. ▶ Most parents are among the strongest supporters of quality sexuality education programmes in schools. Many parents value external support to help them approach and discuss 'sex issues' with their children, ways to react to difficult situations (e.g. when a child watches porn on the Internet or is bullied on social media) and how to access and provide accurate information.
▶ CSE may be good for adolescents, but it is inappropriate for young children	▶ Young children also need information that is appropriate for their age. The Guidance is based on the principle of age- and developmental-appropriateness, reflected in the grouping of learning objectives outlined in Section 5. Additionally, the Guidance provides flexibility to take into account the local and community contexts and encompasses a range of relationships, not only sexual relationships. Children recognize and are aware of these relationships long before they act on their sexuality and therefore need the skills and knowledge to understand their bodies, relationships and feelings from an early age. ▶ The Guidance lays the foundations for healthy childhood by providing children with a safe environment to learn the correct names for parts of the body; understand principles and facts of human reproduction; explore family and interpersonal relationships; learn about safety, prevention and reporting of sexual abuse etc. CSE also provides children with the opportunity to develop confidence by learning about their emotions, self-management (e.g. of hygiene, emotions, behaviour), social awareness (e.g. empathy), relationship skills (e.g. positive relationships, dealing with conflicts) and responsible decision-making (e.g. constructive and ethical choices). These topics are introduced gradually, in line with the age and evolving capacities of the child.

▶ Teachers may be uncomfortable or lacking the skills to teach CSE	▶ Well-trained, supported and motivated teachers play a key role in the delivery of high-quality CSE. Teachers are often faced with questions about growing up, relationships or sex from learners in a school setting, and it is important that they have a suitable and safe way of responding to these questions. ▶ Clear sectoral and school policies and curricula help support teachers, as does institutionalized pre- and in-service teacher training and support from school management. Teachers should be encouraged to develop their skills and confidence through added emphasis on formalizing CSE in the curriculum, as well as stronger professional development and support.
▶ Teaching CSE is too difficult for teachers	▶ Teaching and talking about sexuality can be challenging in social and cultural contexts where there are negative and contradictory messages about sex, gender and sexuality. At the same time, most teachers and educators have the skills to build rapport with learners, to actively listen and help identify needs and concerns and to provide information. Teachers can be trained in CSE content through participatory methodologies and are not expected to be experts on sexuality. This training can be included as part of the curriculum of teacher training institutes (pre-service) or as in-service teacher training.
▶ CSE is already covered in other subjects (biology, life-skills or civics education)	▶ Using the Guidance provides an opportunity to evaluate and strengthen the curriculum, teaching practice and the evidence, based on the dynamic and rapidly changing field of CSE, and to ensure that schools fully cover a comprehensive set of topics and learning objectives, even if the learning is distributed across a range of school subjects. In addition, effective CSE includes a number of attitudinal and skills-based learning outcomes which may not necessarily be included in other subjects.
▶ Sexuality education should promote positive values and responsibility	▶ The Guidance supports a rights-based approach that emphasizes values such as respect, acceptance, equality, empathy, responsibility and reciprocity as inextricably linked to universal human rights. It is essential to include a focus on values and responsibility within a comprehensive approach to sexuality education. CSE fosters opportunities for learners to assess and clarify their own values and attitudes regarding a range of topics.
▶ Young people already know everything about sex and sexuality through the Internet and social media	▶ The Internet and social media can be excellent ways for young people to access information and answers to their questions about sexuality. Young people often use online media (including social media) because they are unable to quickly and conveniently access information elsewhere. However, online media doesn't necessarily provide age-appropriate, evidence-based facts and can in fact provide biased and distorted messages. It is difficult for young people to distinguish between accurate and inaccurate information. While online media can offer a lot of information, it does not offer the space for young people to discuss, reflect and debate the issues, nor to develop the relevant skills. CSE offers a forum for young people to understand and make sense of the images, practices, norms and sexual scripts that they observe via social media and pornography. It provides an opportunity to learn about the aspects of sexuality that are absent from pornography, such as emotional intimacy, negotiating consent and discussing modern contraception. CSE can also support young people to safely navigate the Internet and social media and can help them identify correct and fact-based information.
▶ Religious leaders may not support sexuality education	▶ Religious leaders play a unique role in supporting CSE in schools. Faith-based organizations can provide guidance to programme developers and providers on how to approach religious leaders to begin a discussion about sexual health and sexuality education. Acting as models, mentors and advocates, religious leaders are ambassadors for faith communities that value young people's well-being. Young people seek moral guidance that is relevant to their lives, and all young people deserve reliable information and caring guidance about sexuality that enables them to engage in both emotionally and physically healthy relationships. Sexuality education that is factually inaccurate and withholds information ignores the realities of adolescent life, and puts young people at unnecessary risk of disease and unintended pregnancy and, above all, endangers their lives and human dignity. Many faith communities know from experience, and numerous studies show, that young people tend to delay mature sexual activity when they receive sexuality education that focuses on responsible decision-making and mutual respect in relationships (UNESCO, 2009).
▶ CSE is a means of recruiting young people towards alternative lifestyles	▶ The main principle of the Guidance is that everyone has the right to accurate information and services in order to achieve the highest standard of health and well-being, without making judgement on sexual behaviour, sexual orientation, gender identity or health status. The Guidance takes a rights-based approach that is also focused on gender, and acknowledges that people express themselves differently in all societies, sometimes not conforming to gender or social norms, including on the issue of sexual behaviour and sexual orientation or gender identity. It does not endorse or campaign for any particular lifestyle other than promoting health and well-being for all.

The role of key stakeholders in demonstrating leadership and commitment to CSE

At the national level, ministries of education and health, as well as gender, play a critical role in offering the policy and moral leadership that provides an enabling and supportive environment for strengthening CSE. Equally, they are at the heart of building consensus among the diverse parts of government and civil society that must be involved in developing and delivering sexuality education.

Other key stakeholders that can provide leadership and commitment include parents and parent-teacher associations; educational professionals and institutions, including teachers, head teachers, school inspectors and training institutions; religious leaders and faith-based organizations; teachers' trade unions; researchers; community and traditional leaders; LGBTI groups; NGOs, particularly those working on sexual and reproductive health and rights with young people; people living with HIV; media (local and national); and relevant donors or outside funders.

The role of champions

Engaging with 'champions' can help enhance awareness of and a positive approach to sexuality education. Champions are influential thought leaders, including politicians, celebrities, young people, religious leaders, and others from inside and outside the educational field, who believe in the importance of CSE. They understand the local context and are valued by the communities. Through their networks, they can advocate at national or local level, in parliament, in school or community settings; engage with the press; and use social media to raise awareness of the positive impact of CSE on the health and emotional well-being of young people.

Box 3. Youth participation in CSE advocacy and implementation

The UN Convention on the Rights of the Child recognizes the right to participation: 'to express … views freely in all matters affecting [them], …being given due weight in accordance with [their] age and maturity.' (Article 12). In addition, the 1994 POA of the ICPD specifically recognized young people's right to participate in reproductive health programmes, as did the 2012 Commission on Population and Development outcome document and the World POA on Youth (adopted by the UN in 2007). Young people can play multiple roles to advocate for, develop, implement and evaluate CSE programmes (Kirby, 2009). Evidence from operational research on programme interventions shows that employing young people's ideas, connections and unique expertise in programmatic work increases the reach, attractiveness, relevance and effectiveness of interventions (Jennings, et al., 2006; SRHR Alliance, 2016; Villa-Torres and Svanemyr, 2015; IPPF, 2016).

6.2 Supporting CSE programme planning and implementation

Diverse stakeholders from multiple levels should be involved in the planning and implementation of school-based and out-of-school CSE. National and regional authorities, schools and communities should be engaged, at different stages and to different extents, in the development of national policy; update of curricula; creation of mechanisms and plans for rolling out a new curriculum. The following section provides information on how different actors at different levels can support CSE planning and implementation, both in and out of school.

National and regional level

In some countries, local education ministries have established National Advisory Councils and/or Task Force Committees to inform the development of relevant policies, improve the national curriculum and assist in the development and implementation of CSE programmes.

Council and committee members can often get involved in sensitization and advocacy efforts; review draft materials and improvements for national curricula and policies; and develop a comprehensive work plan for in-classroom delivery, together with plans for monitoring and evaluation. At the policy level, a well-developed national policy on CSE can be explicitly linked to education sector plans, as well as to the national strategic plan and policy framework on HIV and SRH.

School level

Role of school authority and management: overall, a positive school environment has been shown to facilitate the full implementation of programmes, thus supporting their effectiveness (Picot et al., 2012 in UNESCO, 2016c). Some ways that school authorities and management can make a difference include:

- **Providing leadership and management:** school management is expected to take the lead in motivating and supporting CSE, as well as in creating the appropriate climate for implementing CSE and addressing the needs of young people. From a classroom perspective, instructional leadership calls on teachers to lead children and young people towards a better understanding of sexuality through discovery, learning and growth. In a climate of uncertainty or conflict, the leadership abilities among managers and teachers can make the difference between a successful programmatic intervention and a failed one.

- **Creating or strengthening policies that support the provision of CSE:** the sensitive, and sometimes controversial nature of CSE, makes it important for supportive and inclusive laws and policies to be in place, demonstrating that the implementation of CSE is a matter of institutional policy, rather than the personal choice of individuals. Implementing CSE within a clear set of relevant national and school-wide policies or guidelines has numerous advantages, including providing an institutional basis for the implementation of CSE programmes; anticipating and addressing the sensitivities concerning the implementation of CSE programmes; setting standards on confidentiality; setting standards of appropriate behaviour; protecting and supporting the teachers responsible for delivering CSE; and, if appropriate, protecting or increasing their status within the school and the community.

  Although some of the aforementioned issues are defined through pre-existing school policies, in the absence of pre-existing guidance, a policy on CSE will clarify and strengthen the school's commitment to:

  - a curriculum delivered by trained teachers;
  - parental involvement;
  - promoting gender equality and non-discrimination regardless of sex, gender, sexual orientation and gender identity, and respecting the rights of all learners;
  - allocating financial and human resources to support the implementation of CSE;
  - setting up procedures to respond to parental concerns;
  - supporting pregnant learners to continue their education;
  - making the school a safe environment for the provision of CSE, for example by having zero-tolerance policies for sexual harassment and bullying, including stigma and discrimination on the grounds of sexual orientation and gender identity;
  - making the school a health-promoting environment, for example through the provision of clean, private and separate toilets with running water for girls and boys;
  - taking action in cases of policy infringement, for example in case of breach of confidentiality, stigma and discrimination, sexual harassment or bullying;
  - promoting access and links to local SRH services and other services in accordance with local laws; and
  - upholding (and strictly enforcing) professional codes of conduct that prohibit teacher-learner sexual relationships and taking consistent action with teachers found to be in violation of the code of conduct.

Role of teachers: teachers are central to the implementation of CSE. They need to have the confidence, commitment and resources to be able to teach the more complex issues of sexuality and SRH. To implement the CSE curriculum effectively, they must feel supported by a legal framework, the school management and local authorities, and have access to training and resources. CSE is not the effort or the responsibility of any particular teacher, but rather should be a joint effort whereby all educators support each other and share experiences of implementing the CSE programme. Teachers responsible for the delivery of CSE also require training on the specific skills needed to address sexuality accurately and clearly, as well as the use of active, participatory learning methods.

Role of health providers and other non-teaching staff operating within the school setting: the combination of CSE and related services has been shown as an effective way to support young people's SRH (UNESCO, 2015a; Hadley et al., 2016). For example, school nurses can provide additional information and counselling, support classroom activities and refer children and young people to external SRH or other services. All other non-teaching staff, for example, janitors and cleaners, must be aware of the policies and principles of CSE and child protection, as well as the guidelines regarding young people living with HIV, LGBTI and others.

Role of students in school: students need to play an active role in building support for CSE. Student councils, other student groups and individual youth leaders should be actively encouraged to provide input on the design, monitoring and evaluation of CSE programmes; collect information about their peers' needs to develop the justification for CSE; or initiate dialogues with parents and other community members about the importance of CSE in their lives.

Community level

Diverse groups of stakeholders in the community, including faith-based organizations and non-governmental organizations (NGOs):

- Community leaders can pave the way for acceptance and support of CSE programmes implemented in formal and non-formal settings. It is crucial to work with these stakeholders to counter inaccurate information and dispel any existing myths and misconceptions around CSE that the community might have. Community leaders can also provide support for efforts to contextualize the content of the programme.

- Religious and faith-based organizations play an important role in the lives of many communities. The influence and authority that religious leaders have in communities allows them to speak from a theological foundation of respect for human dignity and wholeness (Religious Institute, 2002). It is important to keep a dialogue going with these organizations, as well as with young people

of different faiths. It is only through discussion that the complex issues of the content of CSE programmes can be addressed. Most religions promote building healthy and loving relationships free from coercion and abuse, and all religions want young people to be healthy and happy. Dialogue can help find the balance between what religion teaches, what scientific evidence proves, and what the lived reality is for local young people.

- Local NGOs serve as a valuable resource for schools and teachers to turn to for more information, or to invite as guest speakers to discuss topics that reinforce or complement the CSE curriculum. Some NGOs also have community-based CSE programmes in place.

Parents: young people's perceptions and behaviours are greatly influenced by family and community values, social norms and conditions. Therefore, the cooperation and support of parents, families, and other community actors needs to be sought from the outset and regularly reinforced. It is important to emphasize the primary concern of promoting the safety and well-being of children and young people that is shared by both schools and parents/caregivers. Ensuring that parents/caregivers understand, support and get involved with the delivery of CSE is essential to ensure long-term results. Research has shown that 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 (UNESCO, 2009). The chances of personal growth for children and young people are likely to be much better if teachers and parents support each other in implementing a guided and structured teaching/learning process.

Media and other gatekeepers: the mass media – television, newspapers, magazines and the Internet – has a significant impact on people's ideas and misconceptions regarding CSE. These outlets are not always concerned with the outcome of their messages, and are occasionally more focused on attracting audiences than on promoting healthy sexuality. It is important for the media to have access to evidence-based information to help communicate accurate messages.

Health providers: health providers are well-positioned to support CSE by providing information about the common SRH needs of young people; sharing information and lessons-learned about the outcomes of their education strategies; and by actively participating in efforts to strengthen the link between CSE and health services.

7

Delivering effective CSE programmes

7 - Delivering effective CSE programmes

This section outlines the characteristics, common among evaluated CSE programmes that have been found to be effective in terms of increasing knowledge, clarifying values and attitudes, increasing skills and impacting behaviours. It also includes recommendations for all stages of the development and delivery of CSE including design, implementation monitoring, evaluation and scale-up.

7.1 Introduction

The following characteristics of effective curriculum development, implementation and monitoring are based on findings from a range of studies and reviews of CSE programmes (UNESCO, 2009; WHO Europe and BZgA, 2010; UNFPA, 2014; UNESCO, 2016c; Pound et al., 2017). When developing and delivering CSE, it is important to build on existing standards or guidelines, and to develop clear steps for its implementation and evaluation.

Evidence is increasingly showing that the delivery of CSE is as important as the content. Effective sexuality education must take place in a safe environment, where young people feel comfortable to participate and their privacy is respected, where they are protected from harassment and where the school ethos reflects the principles of the content (Pound et al., 2017).

These recommendations can be complemented by existing practical manuals, guides, toolkits and action frameworks that have been developed by CSE subject matter experts and practitioners in different regions of the world.

7.2 Characteristics of effective curriculum development

During the preparatory phase:

1 **Involve experts on human sexuality, behaviour change and related pedagogical theory:** just like mathematics, science and other fields, human sexuality is an established field based on an extensive body of research and knowledge. Experts familiar with this research and knowledge should be involved in developing, selecting and adapting curricula. Additionally, CSE curriculum developers must be knowledgeable about issues such as gender, human rights and health; as well as the risky behaviours that young people engage in at different ages; what environmental and cognitive factors affect these behaviours; and how best to address those factors through participatory methodologies that address the three domains of learning. CSE curriculum developers also need knowledge about other CSE programmes that have delivered positive outcomes, especially those that addressed similar communities and young people. When developers lack this experience, experts in child and adolescent development and sexuality should be engaged to ensure the appropriate content and context.

2 **Involve young people, parents/family members and other community stakeholders:** the quality of sexuality education is enhanced by systematic youth participation. Learners are not the passive recipients of sexuality education, but rather can, and should, play an active role in organizing, piloting, implementing and improving the content of sexuality education. This ensures that sexuality education is needs-oriented and grounded in the contemporary realities within which young people navigate their sexualities, rather than simply following an agenda determined in advance by educators (WHO Europe and BZgA, 2010). Young people's input can help determine how the curriculum is used by different types of educators, including peer educators, and how to adapt activities to different contexts, including formal and non-formal settings. Parents and community leaders also play an important role. Interventions with higher levels of parental involvement and community sensitization, for example, homework assignments; after-school sessions for parents and children; and encouraging parents to learn about the programme, showed the greatest impact on improving the sexual health of their their children (Wight and Fullerton, 2013 in UNESCO, 2016c).

3 **Assess the social, SRH needs and behaviours of children and young people targeted by the programme, based on their evolving capacities:** the curriculum planning process should take into account evidence-based information on young people´s sexual needs and behaviours, including about existing barriers that lead to unwanted, unintended and unprotected sexual activity. Additionally, the process of developing CSE curricula must consider the evolving capacities of children and young people, as well as their

differing needs based on their particular circumstances, settings, cultural values, etc. It is also important to ensure that the process builds on children's and young people's existing knowledge, positive attitudes and skills. The needs and assets of young people can be assessed through focus groups and interviews with the young people themselves, as well as with professionals who work with them. These interactions can be complemented with reviews of research data from the target group or similar populations.

4 **Assess the resources (human, time and financial) available to develop and implement the curricula:** this is an important step for all programmes. While this may seem obvious, there are numerous examples of curricula that could not be fully implemented or were prematurely terminated because they were not consistent with the resources available, including staff time, staff skills, facility space and supplies.

When developing the curriculum content:

5 **Focus on clear goals, outcomes and key learnings to determine the content, approach and activities:** an effective curriculum has clear health-related goals and behavioural outcomes that are directly related to these goals. In addition to behavioural outcomes, curricula should focus on developing attitudes and skills that contribute to safe, healthy and positive relationships, as well as positive values, including respect for human rights, gender equality and diversity. Emphasis should also be placed on key issues that affect children and young people of different ages, sex and characteristics (e.g. HIV, GBV or unintended pregnancy). For more information, see Section 5. Key concepts, topics and learning objectives.

6 **Cover topics in a logical sequence:** many effective curricula first focus on strengthening and motivating learners to explore values, attitudes and norms concerning sexuality, before going on to address the specific knowledge, attitudes and skills required to develop safe, healthy and positive lifestyles; prevent HIV, STIs and unintended pregnancies; and protect learner's rights and the rights of others.

7 **Design activities that are context-oriented and promote critical thinking:** learners may come from diverse socio-economic backgrounds and differ in their age, gender, sexual orientation, gender identity, family and community values, religion and other characteristics. It is important to implement curricula that pay appropriate attention to the learner's environment, and that promote understanding and critical thinking about existing personal and community values and perceptions of family, community and peers on sexuality and relationships.

8 **Address consent and life skills:** education about consent is essential for building healthy and respectful relationships, encouraging good sexual health and protecting potentially vulnerable people from harm. Teaching young people to acknowledge and respect other people's personal boundaries can help create a society where no one feels ashamed to willingly engage in sexual activity, or to reject it or revoke consent at any point (IPPF, 2015b). Quality education on consent should strive to support young people in assessing risks and protecting themselves from situations that may lead to unwanted sexual practices, and should help them develop the knowledge and confidence to seek positive relationships with other individuals.

Life skills, such as risk assessment and negotiation abilities are essential for children and young people. Risk assessment skills help learners identify their susceptibility to negative or unintended SRH outcomes and understand the implications of HIV, other STIs and unintended pregnancy, among other issues. Testimonials, simulations and role playing have all been found to be useful complements to statistical and other factual information, helping learners explore the concepts of risk, susceptibility and severity. Negotiation skills are essential for children and young people to be able to put into practice protective behaviours such as delaying the age of sexual initiation; responding to peer pressure to engage in sexual practices; and increasing condom use and use of modern contraception when they do decide to become sexually active. Negotiation skills also provide children and young people with the tools to navigate conversations on sexuality, come to agreements and settle differences with others. Role-playing activities representing a range of typical situations are commonly used to help teach these skills, with elements of each skill identified through progressively complex scenarios. Condom demonstrations and visits to places where condoms are available are also used to teach negotiation skills.

9 **Provide scientifically accurate information about HIV and AIDS and other STIs, pregnancy prevention, early and unintended pregnancy and the effectiveness and availability of different methods of protection:** information in the curriculum should be informed by evidence; scientifically accurate and balanced; and neither exaggerating nor understating of the risks or effectiveness of condoms and other forms of contraception (traditional and modern). Many curricula fail to provide adequate information about modern contraception – particularly, but not limited to, emergency contraception and female condoms – or about PrEP and PEP. Abstinence-only programmes are still delivered in many countries despite robust evidence that this approach is ineffective. Abstinence-only programmes are also more likely to contain incomplete or inaccurate information regarding topics such as sexual intercourse, homosexuality, masturbation, abortion, gender roles and expectations, condoms and HIV (UNFPA, 2014).

10 **Address how biological experiences, gender and cultural norms affect the way children and young people experience and navigate their sexuality and their SRH in general:** biological experiences, gender and other cultural norms affect the way children and young people live their sexuality and their SRH in general. Menstruation, for instance, is a significant biological experience for many girls. However, in some resource-poor areas, girls face unique challenges related to menstruation that reinforce gender inequalities (Secor-Turner et al., 2016). Gender discrimination is common, and young women often have less power or control in their relationships, making them more vulnerable to coercion, abuse and exploitation by boys and men, particularly older men. Men and boys may also feel pressure from their peers to fulfill male sexual stereotypes (e.g. physical strength, aggressive behaviours and sexual experience) and engage in harmful behaviours.

In order to effectively promote equal relationships and reduce risky sexual behaviours, curricula need to address and critically examine these biological experiences, gender inequalities and stereotypes. Programmes should discuss the specific circumstances faced by young women and young men and provide effective skills and methods of avoiding unwanted or unprotected sexual activity. These activities should focus on transforming gender inequality, social norms and stereotypes, and should in no way promote harmful gender stereotypes.

11 **Address specific risk and protective factors that affect particular sexual behaviours:** providing clear messages about risky and protective behaviours appears to be one of the most important characteristics of effective programmes. Most effective CSE programmes repeatedly reinforce clear and consistent messages about protective behaviours in a variety of formats. Some examples of these messages include:

- **Preventing HIV and other STIs:** young people should either avoid sexual intercourse or use a condom correctly every time they have sexual intercourse with every partner. Certain effective programmes emphasize being monogamous and avoiding multiple or concurrent sexual partners. Culturally-specific messages in some countries also emphasize the dangers of 'sugar daddies' (older men who offer gifts, cash or favours, often in return for sexual activity) and the increased risks associated with multiple and concurrent partnerships when condoms are not used consistently. Other programmes encourage testing and treatment for STIs, including HIV. Curriculum content and teacher capacity should also keep pace with the latest science and evidence on HIV prevention, including newer biomedical prevention technologies such as PrEP and how young people who need it can access integrated HIV prevention services including condoms, HIV testing, PrEP and PEP (UNAIDS, 2016).
- **Preventing pregnancy:** young people should abstain from sexual relations and/or use modern contraception every time they have sex. Additionally, young people should know where to access SRH services.
- **Preventing gender-based violence and discrimination:** CSE programmes should include clear messages on ways to change behaviours that reinforce inequality (at home, at school and in the community) and on the need to transform harmful practices against women.

Risk and protective factors play an important role in young people's decision-making about sexual behaviour. They include cognitive and psychosocial factors, as well as external factors, such as access to adolescent-friendly health and social support services. Curriculum-based programmes, especially school-based programmes, typically focus on internal cognitive factors, although they also include information on how to access reproductive health services. The knowledge, values, norms, etc. that are highlighted in sexuality education need to also be supported by social norms and promoted by trusted adults who both model and reinforce them.

12 **Address how to manage specific situations that might lead to HIV infection, other STIs, unwanted or unprotected sexual intercourse or violence:** it is important, ideally with the input of young people themselves, to identify the specific situations in which young people run the risk of being pressured into unwanted sexual activity, and to rehearse strategies for avoiding or negotiating them. It is equally critical for all young people to understand consent and how to avoid pressuring others into unwanted situations or actions. In communities where drug and/or alcohol use is associated with unprotected sexual intercourse, it is also important to address the impact of drugs and alcohol on sexual behaviour.

13 **Address individual attitudes and peer norms concerning condoms and the full range of contraceptives:** individual attitudes and peer norms affect condom and contraceptive use. Effective CSE curricula present clear messages about condoms and other modern contraceptive methods, along with accurate information about their effectiveness. These programmes also help students explore their attitudes towards condoms and modern contraception, and help identify perceived barriers to their use. They offer opportunities to discuss ways to overcome these barriers, for example, difficulties obtaining and carrying condoms; possible embarrassment when asking one's partner to use a condom; or any difficulties actually using a condom.

14 **Provide information about what services are available to address the health needs of children and young people, especially their SRH needs:** effective CSE curricula include information on how to access youth-friendly health services – including, but not limited to counselling on sexuality and relationships; menstrual health management; modern contraception and pregnancy testing; abortion (where legal); STI and HIV prevention, counselling, testing and treatment; vaccination against HPV; VMMC; and FGM/C prevention and management of consequences, among others.

The activities, included as part of the curriculum, should also encourage young people to understand how they can and should play an active role in the decision-making around their care, for example by reflecting on the importance of informed consent, privacy and confidentiality; and learning about how existing legal frameworks support or hinder their ability to make decisions about their health. Finally, the curriculum should help learners understand how they can play an active role in supporting their peers or partners to access SRH services, for example by reflecting on the barriers that some youth may face when accessing these services because of their sex, sexual orientation, gender identity, geographical location, marital status, disability; and learning about existing legal requirements regarding the provision of care (IPPF, 2017).

Table 4. Characteristics of an effective CSE curriculum

Preparatory phase

1. Involve experts on human sexuality, behaviour change and related pedagogical theory.
2. Involve young people, parents/family members and other community stakeholders.
3. Assess the social, SRH needs and behaviours of children and young people targeted by the programme, based on their evolving capacities.
4. Assess the resources (human, time and financial) available to develop and implement the curricula.

Content development

5. Focus on clear goals, outcomes and key learnings to determine the content, approach and activities.
6. Cover topics in a logical sequence.
7. Design activities that are context-oriented and promote critical thinking.
8. Address consent and life skills.
9. Provide scientifically accurate information about HIV and AIDS and other STIs, pregnancy prevention, early and unintended pregnancy and the effectiveness and availability of different methods of protection.
10. Address how biological experiences, gender and cultural norms affect the way children and young people experience and navigate their sexuality and their SRH in general.
11. Address specific risk and protective factors that affect particular sexual behaviours.
12. Address how to manage specific situations that might lead to HIV infection, other STIs, unwanted or unprotected sexual intercourse or violence.
13. Address individual attitudes and peer norms concerning condoms and the full range of contraceptives.
14. Provide information about what services are available to address the health needs of children and young people, especially their SRH needs.

7.3 Designing and implementing CSE programmes

1 **Decide whether to use a stand-alone or integrated programme** – decisions need to be made about whether sexuality education should be taught as a stand-alone subject; integrated within an existing mainstream subject, such as health or biology; taught as both a stand-alone subject and integrated across the curriculum; or included in the life skills programme (UNESCO, 2015a). This decision will be influenced by general educational policies, availability of resources, competing priorities in the school curriculum, needs of learners, community support for CSE programmes and timetabling issues. A pragmatic response might acknowledge that, while it would be ideal to introduce sexuality education as a separate subject, or place CSE content within one exisiting subject like life skills; it may be more practical to build upon and improve what teachers are already teaching, and to integrate CSE into existing subjects such as social science, biology or guidance counselling. In these situations, it is important to safeguard against the dilution of the CSE content and consider the increased teacher training requirements and teaching and learning materials needed to cater for CSE content across various carrier subjects.

Other important considerations include whether CSE content will be considered mandatory as per the mode of delivery (stand-alone versus integrated) and whether the CSE-related content will be formally examined. Both teachers and learners tend to take the content more seriously when exams or other assessment approaches are involved, and exams also provide more opportunities to measure teacher effectiveness and learner outcomes.

Table 5. Stand-alone or integrated CSE - key considerations

Stand-alone	Integrated
Reflects importance of the subject as it has its own separate status.	Complements the existing curriculum subjects and specific skills or knowledge areas are linked to other themes (e.g. social studies, life skills).
May not be sufficient time or space in the curriculum to teach a whole separate subject.	In-depth aspects of learning, or challenging topics, may be squeezed out by the other subject content deemed more critical for examinations as teachers try to 'fit it in'.
Only one teacher needs to be trained – but the subject is also dependent on a single individual's commitment and abilities.	Many teachers require training, support and a coordination mechanism to ensure that the full 'curriculum' is being covered across all subjects.
Assessment and examination may be more straight-forward.	Examination spread across multiple subjects in line with curriculum framework makes it possibly more complicated to have an overview of progress and assessment for the full curriculum.
Potentially cost-effective in term of numbers of teachers to be trained, and the number of teaching and learning resources to be developed.	Costs of training, materials and assessment may be spread across different existing areas by adding the specific, relevant CSE components.
Teachers may feel isolated or lacking in support for this sensitive subject.	Greater number of staff involved, and understanding of CSE can lead to a more holistic 'whole school' approach.

2 **Include multiple, sequential sessions over several years:** to maximize learning, multiple topics addressing sexuality need to be covered in an age-appropriate manner over the course of several years, using a spiral-curriculum approach. It is important to provide young people with clear messages about behaviour, and reinforce important concepts over the course of several years. Both risk and protective factors that affect decision-making need to be addressed to reduce sexual risk-taking among young people. These approaches take time; a review of studies from sub-Saharan Africa (Michielsen et al., 2010 in UNESCO, 2016c) reported greater impact among young people that received more of the intervention. Since the duration and intensity of of CSE is a critical factor in its effectiveness, the content needs to be taught in timetabled classroom lessons that can be supplemented by special activities, projects and events (Pound et al., 2017). Positive results have been seen with programmes that offer 12 or more sessions, and sometimes

30 or more sessions, with each session lasting approximately 50 minutes. Given this guidance, classroom curricula and lesson planning during the school year, and across school years, must carefully allocate adequate time and space to CSE to increase its effectiveness (UNESCO, 2009).

3 **Pilot test the CSE curriculum:** pilot-testing the CSE curriculum allows for adjustments to be made to any of its components. This gives programme developers an opportunity to fine-tune the content and discover important changes that need to be made. The entire curriculum should be pilot-tested, and practical feedback from participants should be obtained, especially on what elements of the curriculum participants thought worked well and those that didn't, as well as ways to make weak elements stronger, more relevant and more effective.

4 **Employ participatory teaching methods that actively involve children and young people and help them internalize and integrate information:** educators should use a diverse range of interactive, participatory and learner-centred approaches that enable learning across the key domains of learning (knowledge, attitudes, skills). Findings from high-quality trials suggest that the most effective school-based interventions are interactive and provide a variety of activities (Lopez et al., 2016 in UNESCO 2016c) complementing knowledge-based learning with practical skills, and the opportunity to reflect on values and attitudes. Methods should be matched to specific learning objectives, for example, role-playing, integrating ICT use in assignments, anonymous question boxes, lecture and information sessions and group reflection (Amaugo et al., 2014; Fonner et al., 2014; Tolli, 2012).

5 **Select capable and motivated educators to implement the curriculum in schools and non-formal settings:** sexuality education programmes are most commonly delivered by teachers, peers, health professionals or a combination of all three (Fonner et al., 2014). According to Pound et al. (2016), young people's views on the qualities of a good educator [include] that they: (a) are knowledgeable; (b) have expertise in sexual health; (c) be professional; (d) be specifically trained in [sex and relationship education]; (e) are confident, unembarrassed, straightforward, approachable and unshockable, experienced at talking about sex, use everyday language; (f) are trustworthy, able to keep information confidential; (g) have experiential knowledge and feel comfortable with their own sexuality; (h) are good at working with young people; (i) have the ability to relate to and accept young people's sexual activity; (j) are respectful of young people and their autonomy, treat them as equals; (k) have similar values to youth, provide balanced views and are non-judgmental.

Additionally, educators should be able to clarify and separate personal values and attitudes from professional roles and responsibilities. Taking the views of young people into consideration is vital to ensuring that a CSE programme has positive outcomes.

Educators may be existing classroom or subject teachers (especially health education or life-skills education teachers) or specially trained teachers who only teach sexuality education and move from classroom to classroom covering all relevant grades in the school. Studies have demonstrated that programmes can be effectively delivered by both types of teachers (Kirby et al., 2006). The effectiveness of the programme can be affected by many factors, including the level and quality of training that adults receive; the quality of the programme; whether the programme is delivered as intended; and the school and wider social environment (UNESCO, 2016c).

6 **Provide educators with sensitization, values clarification, quality pre- and on-the-job training and continuous professional development opportunities:** delivering sexuality education often involves new concepts and teaching methods, and sensitization, values clarification and training opportunities are important for teachers. These processes should teach and provide practice in participatory learning methods; provide a good balance between learning content and skills; be based on the curriculum that is to be implemented; provide opportunities to rehearse key lessons in the curriculum; have clear goals and objectives; and provide constructive feedback to each teacher on their effectiveness in delivering the content. Additionally, the training should help educators distinguish between their personal values and the health needs of learners; increase the confidence and capability of the educators; encourage educators to teach the curriculum in full, not selectively; address challenges that will occur in some communities (e.g. very large class sizes); last long enough to cover the most important knowledge content and skills; and should allow teachers time to personalize the training and raise questions and issues. If possible, the training will also address teachers' own concerns about their SRH and sexuality in general. Finally, experienced and knowledgeable trainers should conduct the training, and at the end of the training, solicit participants' feedback.

School managers should provide encouragement, guidance and support to teachers involved in delivering it. Supervisors need to make sure that the curriculum is being implemented as planned, that all parts are fully implemented (not just the biology content that often may be part of examinations) and that teachers have access to support to help them respond to new and challenging situations as they arise during the course of their work. It is necessary for supervisors to stay informed about important developments in the field of sexuality education in order to make any necessary adaptations to the school's programme. This may include opportunities for supervisers and school

inspectors to participate in some of the same or modified teacher training modules that classroom teachers undergo, as well as have nationally endorsed observation tools that will systematically guide the monitoring and evaluation of CSE (classroom) delivery.

7 **Ensure confidentiality, privacy and a safe environment for all children and young people:** considering that sexuality is a subject that can arouse strong emotions, reactions and feelings of anxiety, embarrassment and vulnerability, among others (Pound et al., 2016, p. 4), it is important for all children and young people to have a confidential, private and safe environment to share their questions, learn and participate without feeling singled-out. This sense of safety can be achieved by ensuring that teachers are well-trained to handle difficult questions and testimonials, and by encouraging smaller class sizes or small-group discussions. Educators also need to be aware that learners that have experienced sexual abuse might decide to disclose this information once they have learned more about their rights. Schools should be prepared, with procedures in place in line with local laws and policies, to support and refer those who disclose or seek help and require additional services.

8 **Implement multicomponent initiatives:** one of the most promising developments in ensuring the SRH of young people is multicomponent programmes that offer school-based sexuality education alongside extra-curricular, community or health facility-based services. Some reports suggest that the highest levels of impact are seen when school-based programmes are complemented with community elements, including training health providers to deliver youth-friendly services, condom distribution and involving parents and teachers (Chandra-Mouli et al., 2015; Fonner et al., 2014; UNESCO, 2015a; 2016c).

9 **Assess the appropriateness of using digital media as a delivery mechanism:** digital media-based delivery of sexuality education appears to offer rich opportunities, especially because of the ability to tailor digital interventions to the specific needs of users, including sub-groups of young people who may not be adequately addressed in static, curriculum-based programmes that are delivered to school classes (UNESCO, 2016c). Recent studies of sexuality education programmes delivered via digital media have found changes in target behaviours, including delayed initiation of sex, as well as changes in knowledge and attitudes, for example on condom self-efficacy, abstinence attitudes and knowledge of HIV/STIs and pregnancy (Guse et al., 2012 in UNESCO 2016c).

Implementing CSE using digital media should take into careful consideration a wide range of factors, for example how much technological support and equipment is required to adequately implement the programme. In many cases, mobile phones are widely available and/or cheap to provide, so they may offer an effective means for communicating information to young people. There are also ethical implications related to providing sexuality education through digital media, whether as part of a larger curriculum-based programme or as a stand-alone intervention, including whether young people's online behaviour or personal profiles should be revealed to programme staff, teachers or researchers (Guse et al., 2012 in UNESCO, 2016c). The opportunities and risks that digital-media delivery of sexuality education presents may be best understood by involving young people in the planning process, as they are often far more expert users of these technologies than their teachers, parents or other elders.

10 **Maintain quality when replicating a CSE programme:** programmes that are found to be effective in one country or culture can be successfully replicated in different contexts, even when they are transported from high- to low-resource settings (Gardner et al., 2015; Leijten et al., 2016). However, social, community, programme, practitioner and organizational influences, and even the implementation process itself, can impact the implementation quality of replicated programmes (Durlak, 2013 in UNESCO 2016c). This includes adaptations intended to meet the particular needs of the environment, the school, the students, the faculty or even the community. Adaptation should be done with careful consideration and understanding of the core components of the programme or curriculum. Some adaptations are likely to have a limited effect on fidelity. These can include, for example, changing language (translating and/or modifying vocabulary); replacing images to show youth, families or situations that look like the target audience or context and replacing cultural references. Such risky adaptations include: reducing the number or length of sessions, reducing participant engagement, eliminating key messages or skills to be learned, or removing topics completely, changing the theoretical approach, using staff or volunteers who are not adequately trained or qualified, and/or using fewer staff members than recommended (O'Connor et al., 2007 in UNESCO 2016c). Changing some language, or images or cultural references to make the content more relevant does not impact on effectiveness.

Table 6. Designing and implementing CSE programmes

1. Decide whether to use a stand-alone or integrated programme.
2. Include multiple, sequential sessions over several years.
3. Pilot test the CSE curriculum.
4. Employ participatory teaching methods that actively involve children and young people and help them internalize and integrate information.
5. Select capable and motivated educators to implement the curriculum in schools and non-formal settings.
6. Provide educators with sensitization, values clarification, quality pre- and on-the-job training and continuous professional development opportunities.
7. Ensure confidentiality, privacy and a safe environment for children and young people.
8. Implement multicomponent initiatives.
9. Assess the appropriateness of using digital media as a delivery mechanism.
10. Maintain quality when replicating a CSE programme.

7.4 Monitoring and evaluation of CSE programmes

1 **Assess the programme and obtain ongoing feedback from schools, communities, educators and learners about how the programme is achieving its outcomes:** regular monitoring and assessment of the programme should involve frequent reviews of data, for example, the number of participants, demographics of learners – and accessing documentation on teacher training, messaging and interventions. Monitoring and assessment should also include sample classroom observations and interviews to gather data on the teaching approaches being used, the fidelity to the curriculum, student perceptions of their learning experience, and the safety of the learning environment (UNFPA, 2014).

A variety of monitoring and evaluation tools have been developed in recent years that can be adapted to different contexts, such as the Sexuality Education Review and Assessment Tool (UNESCO, 2011b) and IPPF's Inside and Out (IPPF, 2015a) which provide a framework for assessing the scope, content and delivery of sexuality education both in and out of school.

2 **Integrate one or more key indicators in national education monitoring systems to ensure systematic measurement of the delivery of sexuality education**: systematic monitoring of the implementation of sexuality education can be done through national systems where regular data collection on a range of education questions can include one or two key questions on sexuality education. The following indicator is recommended for use by countries within their Education Management Information System (EMIS). The indicator was developed by UNESCO and the Inter-Agency Task Team on Education to examine the quality, comprehensiveness and coverage of life skills-based HIV and sexuality education as part of a wider monitoring framework for education sector responses to HIV and AIDS (UNESCO, 2013a).

The indicator can be tracked through either EMIS Annual School Census or a school-based survey. The survey allows for a more detailed analysis of the breadth of content being taught and may be carried out through a nationally representative sample of schools. In the latter case, 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, while the desirable topics are those that have an indirect impact on HIV prevention, but are important as part of an overall sexuality education programme. See *Appendix VIII* for full information on the proposed essential and desirable criteria.

Table 7. Indicator recommended for use by countries within their Education Management Information System (EMIS) to examine the quality, comprehensiveness and coverage of life skills-based HIV and sexuality education

Did students at your school receive comprehensive life skills-based HIV and sexuality education in the previous academic year? Yes/No If Yes, indicate which of these topics were covered in the life skills-based HIV and sexuality education programme:		
Teaching on generic life skills (e.g. decision-making/communications/refusal skills).	Yes	No
Teaching on sexual reproductive health/sexuality education (e.g. teaching on human growth and development, family life, reproductive health, sexual abuse, transmission of STIs).	Yes	No
Teaching on HIV transmission and prevention.	Yes	No

Source: UNESCO. 2013a. *Measuring the education sector response to HIV and AIDS: Guidelines for the construction and use of core indicators*. Paris, UNESCO.

3 Evaluate the outcomes and impact of the programme:

Outcome evaluation assesses risk/protective factors such as changes in attitudes, behaviours or skills, percentage of young people reached in the identified target groups, and other short-term indicators. Evidence for some indicators can be collected through specific types of research. For example, interviews with the target population and analysis of programme monitoring data can be used to assess young peoples' participation in CSE. Peer-review methodologies – in which members of the beneficiary group conduct conversational interviews with other programme beneficiaries – offer an opportunity to gain insight into the stories and perspectives of beneficiaries (IPPF, 2013). Direct observation and interviews can be used to assess young people's ability to demonstrate critical skills, while validated scales and surveys can be used to provide information on changes in knowledge, attitudes and practices, for example, the 'self-esteem scale', the 'correct condom use self-efficacy scale', the 'Hemingway Measure of Adolescent Connectedness', the 'parent-adolescent communication scale' and the 'sexual relationship power scale', among others (UNFPA, 2014).

Impact evaluation links observed outcome changes to a particular programme. Indicators include ultimate programme goals, for example, reduced rates of HIV and AIDS, unintended pregnancy, and STIs; gender equality or other outcomes that may have been identified for inclusion in the goals of a CSE programme in a specific setting. Impact is assessed using research methods such as randomized controlled trials that allow causal attribution. However, monitoring the impact of CSE according to health indicators such as adolescent pregnancy or HIV incidence can be challenging. It is important to remember that other factors, such as access to services, may play an important role in the changes observed (UNESCO, 2014a).

7.5 Scaling up CSE programmes

In order to have a significant impact, high-quality sexuality education must be delivered at scale on a sustained basis, and must become institutionalized within national systems of education. In particular, when CSE training is established in teacher-training colleges, the country benefits from a constantly expanding workforce capable of covering the comprehensive range of CSE topics and delivering them effectively. This commitment to investing in the future growth of CSE delivery contributes to sustainability and implementation fidelity. This investment also mititgates future costs for in-service teacher training which may need to be implemented in an ad-hoc manner if CSE is not systematically integrated into teacher training. The institutionalization of CSE is a key contributor to social change, influencing social and gender norms that may ultimately benefit population-level public health indicators, as well as the well-being and development of adolescents. The scaling-up of CSE may also involve the institutionalization of linkages between education and health services, through school-level referral mechanisms and national level coordination approaches.

UNESCO has identified ten key principles for scaling up sexuality education (UNESCO, 2014):

Box 4. UNESCO's ten key principles for scaling up sexuality education

1. Choose an intervention/approach that can be scaled up within existing systems.
2. Clarify the aims of scaling up and the roles of different players, and ensure local/national ownership/lead role.
3. Understand perceived need and fit within existing governmental systems and policies.
4. Obtain and disseminate data on the effectiveness of pilot programmes before scaling up.
5. Document and evaluate the impact of changes made to interventions on programme effectiveness.
6. Recognize the role of leadership.
7. Plan for sustainability and ensure the availability of resources for scaling up or plan for fundraising.
8. Plan for the long-term (not donor funding cycles) and anticipate changes and setbacks.
9. Anticipate the need for changes in the 'resource team' leading the scaling up process over time.
10. Adapt the scaling up strategy with changes in the political environment; take advantage of 'policy windows' when they occur.

Scaling up requires favourable conditions and actions to introduce and implement sexuality education. According to UNESCO (2010), levers of success have been found to include:

- a commitment to addressing both HIV and sexuality education reflected in a favourable policy context;
- partnerships (and formal mechanisms for these), for example between education and health ministries, and between government and civil society organizations;
- organizations and groups that represent and contribute to young peoples' perspectives;
- collaborative processes of curriculum review;
- civil society organizations willing to promote the cause of CSE, even in the face of considerable opposition;
- identification and active involvement of 'allies' among decision-makers;
- availability of appropriate technical support (such as from UN partners and international non-governmental bodies) for example, in relation to: sensitization of decision-makers; promoting the use of participatory learning methods by teachers; and engagement in international networks and meetings;
- removal of specific barriers to CSE, such as the withdrawal of homophobic teaching material.

In many countries, national policies and strategies on sexuality education are in place. However, implementation of these programmes has been limited and patchy. Nonetheless, in a small and growing number of low and middle-income countries, concerted, government-led efforts are underway and taking hold, which are both large in scale (i.e. they cover all or most regions of a country), and sustained (i.e. their funding is not limited to a defined period).

Critical to the success in these countries were: strong leadership from the government; partnerships between the government and experienced non-government organizations and universities; adequate resources; and, a shared commitment between stakeholders to the long process of translating policy and plans into actions which ultimately will have an impact in young people's lives.

While many scaled-up programmes have shortcomings and faced challenges in sustaining their achievements, there is strong indication that, with the right mix of commitment, expertise, effort and resources, scaling up sexuality education is possible in all regions of the world.

Rawpixel.com/Shutterstock.com

8

References

8 - References

Adeyemi, B. A. 2008. Effects of cooperative learning and problem-solving strategies on junior secondary school students' achievement in social studies. *Journal of Research in Educational Psychology*, Vol. 6, No. 3, pp. 691-708.

Advocates for Youth, Answer, GLSEN, the Human Rights Campaign, Planned Parenthood Federation of America and the Sexuality Information and Education Council of the U.S. 2015. *A Call to Action: LGBTQ youth need inclusive sex education.* http://www.advocatesforyouth.org/storage/advfy/documents/a%20call%20to%20action%20lgbtq%20youth%20need%20inclusive%20sex%20education%20final.pdf (Accessed 30 April 2017).

Ahmad, F. and Aziz, J. 2009. Students' perceptions of the teachers' teaching of literature communicating and understanding through the eyes of the audience. *European Journal of Social Sciences*, Vol. 7, No. 3, pp. 17-39.

Amaugo, L.G., Papadopoulos, C., Ochieng, B. and Ali, N. 2014. The effectiveness of HIV/AIDS school-based sexual health education programmes in Nigeria: A systematic review. *Health Education Research*, Vol. 29, No. 4, pp. 633-648. https://pdfs.semanticscholar.org/a82e/36dbd9ab9171656d6fa6d9cce134726c124a.pdf (Accessed 5 May 2017).

Arends, R. I. 1997. *Classroom Instruction and Management*. Boston, U.S., McGraw Hill.

Ayot, H. O. and Patel, M. M. 1992. *Instructional Methods*. Nairobi, Educational Research and Publications Ltd.

Baltag, V., and Sawyer, S.M. 2017. Quality healthcare for adolescents. In: Cherry A., Baltag V., Dillon M. (eds). *International Handbook on Adolescent Health and Development: The public health response.* New York, Springer International Publishing.

Barth, J., Bermetz, L., Heim, E., Trelle, S. and Tonia, T. 2012. The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health*. Vol 58, No 3, pp 469-83. DOI: 10.1007/s00038-012-0426-1.

Bekker, LG., Johnson, L., Wallace, M. and Hosek, S. 2015. Building our youth for the future. *Journal of the International AIDS Society,* 18 (2 Suppl 1): 20076. DOI: 10.7448/IAS.18.2.20027. http://www.jiasociety.org/index.php/jias/article/view/20027/html (Accessed 24 August 2017).

Birungi, H., Mugisha, J. F. and Nyombi, J. K. 2007. Sexuality of young people perinatally infected with HIV: A neglected element in HIV/AIDS programming in Uganda. *Exchange on HIV/AIDS, Sexuality and Gender*, No. 3, pp. 7-9.

Blum, R.W., Mmari, Kristin Nelson. 2005. *Risk and Protective Factors Affecting Adolescent Reproductive Health in Developing Countries*. Geneva, WHO/ Baltimore, Johns Hopkins Bloomberg School of Public Health.

Bridges, A. J., Wosnitzer, R., Scharrer, E., Sun, C. and Libermann, R. 2010. Aggression and sexual behavior in best-selling pornography videos: A content analysis update. *Violence Against Women*, Vol. 16, No. 10, pp. 1065-1085.

Brown, J. and L'Engle, L. 2009. X-rated: Sexual attitudes and behaviours associated with US early adolescents exposure to sexually explicit media. *Sage Journals.* http://journals.sagepub.com/doi/abs/10.1177/0093650208326465 (Accessed 30 May 2017).

Bundeszentrale für gesundheitliche Aufklärung (BzGA), UNFPA and WHO. 2015. Sexuality Education Policy Brief No. 1. Cologne, Germany, BzGA. http://eeca.unfpa.org/sites/default/files/pub-pdf/GAKC_Policy_Brief_No_1_rz.pdf (Accessed 30 April 2017).

Bundeszentrale für gesundheitliche Aufklärung (BzGA), UNFPA and WHO. 2016. *Sexuality Education Policy Brief No. 2.* Cologne, Germany, BzGA. http://www.bzga-whocc.de/fileadmin/user_upload/Dokumente/Sexuality_education_Policy_brief_No_2.pdf (Accessed 30 April 2017).

Cash, S.J. and A. Bridge, J.A. Epidemiology of Youth Suicide and Suicidal Behavior. *Current Opinion in Pediatrics*. 21(5):613–619, October 2009 - Volume 21 - Issue 5 - p 613–619. DOI: 10.1097/MOP.0b013e32833063e1 (Accessed 5 May 2017).

Cathy, J. 2011. *Theory of Change Review*: A report commissioned by Comic Relief.

Chandra-Mouli, V., Lane, C. and Wong, S. 2015. What does work in adolescent sexual and reproductive health: A review of evidence on interventions commonly accepted as best practices. *Global Health: Science and Practice*, Vol. 3, pp. 333-340.

Chandra-Mouli, V. and Vipul Patel, S. 2017. Mapping the knowledge and understanding of menarche, menstrual hygiene and menstrual health among adolescent girls in low and middle-income countries. *Reproductive Health*, Vol. 1, No. 14, pp. 14-30.

Child Rights International Network. 2016. *Rights, Remedies and Representation: Global report on access to justice for children*. London, Child Rights International Network. https://www.crin.org/sites/default/files/crin_a2j_global_report_final_1.pdf (Accessed 30 April 2017).

Constantine, N. A., Jerman, P., Berglas, N. F., Angulo-Olaiz, F.,

Chou, C. P. and Rohrbach, L. A. 2015b. Short-term effects of a rights-based sexuality education curriculum for high-school students: a cluster-randomized trial. *BioMed Central Public Health*, 15,p. 293. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/662/CN-01109662/frame.html doi:10.1186/s12889-015-1625-5

Council of Europe. 2014. *Sexual Orientation and Gender Identity: Questions and answers*. Brussels, Council of Europe. https://edoc.coe.int/en/lgbt/7031-sexual-orientation-and-gender-identity-sogi-questions-and-answers.html (Accessed 4 May 2017).

Dicenso, A., Guyatt, G., Willan, A. and Griffith, L. 2002. Interventions to reduce unintended pregnancies among adolescents: Systematic review of randomised controlled trials. *British Medical Journal*, Vol. 324, No. 7351, pp. 1426-1426.

Döring, N. 2014. Consensual sexting among adolescents: Risk prevention through abstinence education or safer sexting? *Cyberpsychology: Journal of Psychosocial Research on Cyberspace*, Vol. 8, No. 1. https://cyberpsychology.eu/article/view/4303/3352 (Accessed 30 May 2017).

Döring, N., Daneback, K., Shaughnessy, K., Grov, C. and Byers, E. S. 2015. Online sexual activity experiences among college students: A four-country comparison. *Archives of Sexual Behavior*. https://www.researchgate.net/publication/286638680_Online_Sexual_Activity_Experiences_Among_College_Students_A_Four-Country_Comparison

Duflo, E., Dupas, P., Kremer, M. and Sinei, S. 2006. *Education and HIV/AIDS Prevention: Evidence from a randomized evaluation in Western Kenya*. Boston, Department of Economics and Poverty Action Lab.

Dupas, P. 2006. *Relative Risks and the Market for Sex: Teenagers, sugar daddies and HIV in Kenya*. Hanover, Dartmouth College.

Durlak, J.A., Weissberg, R.P., Dymnicki, A.B., Taylor, R.D., and Schellinger, K. B. 2011. The Impact of Enhancing students' Social and Emotional Learning: A meta-analysis of school-based universal interventions. *Child Development*. Volume 82, Issue 1, pp. 405–432. DOI: 10.1111/j.1467-8624.2010.01564.x . http://onlinelibrary.wiley.com/doi/10.1111/j.1467-8624.2010.01564.x/abstract

Economic and Social Commission for Asia and the Pacific (ESCAP). 2013. *Report of the Sixth Asian and Pacific Population Conference*. Bangkok, ESCAP. http://www.unescapsdd.org/files/documents/Report of the Sixth APPC.pdf

Elder, S. K. 2014. *Labour Market Transition of Young Women and Men in Sub-Saharan Africa. Work 4 Youth Publication Series* No. 9. Geneva, Youth Employment Programme, Employment Policy Department.

European Union Agency for Fundamental Rights. 2014. *Violence against Women, an EU-wide Survey: Main results report*. http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report (Accessed 4 May 2017).

Fisher, J. and McTaggart J. 2008. *Review of Sex and Relationships Education in Schools*. Geneva, UNAIDS. http://www.cornwallhealthyschools.org/documents/SRE final jim knoght review recommedations.pdf (Accessed 30 May 2017).

Fonner, V. A., Armstrong, K. S., Kennedy, C. E., O'Reilly, K. R. and Sweat, M. D. 2014. School based sex education and HIV prevention in low- and middle-income countries: A systematic review and meta-analysis. *PLoS One*, 9(3), e89692. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0089692. doi:10.1371/journal.pone.0089692

Gardner, F., Montgomery, P. and Knerr, W. 2015. Transporting evidence-based parenting programs for child problem behavior (Age 3-10) between countries: Systematic review and meta-analysis. *Journal of Clinical Child and Adolescent Psychology*. 1-14. http://www.tandfonline.com/doi/full/10.1080/15374416.2015.1015134

Garofalo, R., Wolf, R., Wissow, L., Woods, E. and Goodman, E. 1999. Sexual orientation and risk of suicide attempts among a representative sample of youth. *Archives of Pediatrics and Adolescent Medicine*, Vol. 153, No. 5.

Giroux, H. A. 1994. Toward a pedagogy of critical thinking. In *Re-Thinking Reason: New Perspectives in Critical Thinking*. Kerry S. Walters (ed.). Albany, SUNY Press.

Gordon, P. 2008. *Review of Sex, Relationships and HIV education in Schools*. Paris, UNESCO.

Gordon, P. 2010. *Sexuality Education and the Prevention of Violence*. Council of Europe. www.coe.int/t/dg3/children/1in5/source/publicationsexualviolence/ (Accessed 4 May 2017).

Goulds, S. 2015. *Because I Am a Girl*. Toronto, Plan. (Accessed 4 May 2017).

The Guttmacher Institute. 2014. Intended and unintended pregnancies worldwide in 2012 and recent trends. *Studies in Family Planning*, Vol. 45, No. 3. https://www.guttmacher.org/sites/default/files/article_files/j.1728-4465.2014.00393.x.pdf (Accessed 4 May 2017).

The Guttmacher Institute. 2015a. *Adolescent Pregnancy and Its Outcomes Across Countries Factsheet*. New York, The Guttmacher Institute. https://www.guttmacher.org/fact-sheet/adolescent-pregnancy-and-its-outcomes-across-countries (Accessed 4 May 2017).

Guttmacher Institute. 2015b. *Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries*. New York, The Guttmacher Institute. https://www.guttmacher.org/fact-sheet/adolescent-womens-need-and-use-sexual-and-reproductive-health (Accessed 4 May 2017).

Haberland, N. 2015. The case for addressing gender and power in sexuality and HIV education: A comprehensive review of evaluation studies. *International Perspectives on Sexual and Reproductive Health*, Vol. 41, No. 1, pp. 31-42. https://www.guttmacher.org/journals/ipsrh/2015/03/case-addressing-gender-and-power-sexuality-and-hiv-education-comprehensive (Accessed 30 April 2017).

Haberland, N., Rogow, D. 2015. Sexuality education: Emerging trends in evidence and practice. *Journal of Adolescent Health*, Vol. 56, No. 1, pp. 15-21.

Hadley, A., Ingham, R. and Chandra-Mouli, V. 2016. Teenage pregnancy strategy for England. *The Lancet*, Volume 388, No. 10044. DOI: http://dx.doi.org/10.1016/S0140-6736(16)30619-5. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30619-5/fulltext?rss%3Dyes. (Accessed 4 May 2017).

Hall, W., Patton, G., Stockings, E., Weier, M., Lynskey, M., Morley, K. and Degenhardt, L. 2016. Why young people's substance use matters for global health. *The Lancet Psychiatry*, Vol. 3, No. 3, pp. 265-279.

Hillier, L., Jones, T., Monagle, M., Overton, N., Gahan, L., Blackman, J. and Mitchell, A. 2010. *Writing Themselves in 3 (WTi3). The third national study on the sexual health and wellbeing of same sex attracted and gender questioning young people*. Melbourne, Australian Research Centre in Sex, Health and Society and La Trobe University.

Hughes, K., Bellis, M., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespeare, T. and Officer, A. 2012. Prevalence and risk of violence against adults with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, Vol. 379, No. 9826, pp. 1621-1629.

International Planned Parenthood (IPPF). 2013. *Explore; Toolkit for involving young people as researchers in sexual and reproductive health programmes. Rapid PEER review handbook*. London, IPPF. https://www.rutgers.international/sites/rutgersorg/files/pdf/AW_Explore-PEER%20Handbook.pdf (Accessed 25 April 2017).

International Planned Parenthood Federation (IPPF). 2015. *Teaching about Consent and Healthy Boundaries: A guide for educators*. London, IPPF. https://www.ifpa.ie/sites/default/files/documents/Reports/teaching_about_consent_healthy_boundaries_a_guide_for_educators.pdf (Accessed 4 May 2017).

International Planned Parenthood Federation (IPPF). 2016. *Everyone's Right to Know: Delivering comprehensive sexuality education for all young people*. London, IPPF. http://www.ippf.org/sites/default/files/2016-05/ippf_cse_report_eng_web.pdf (Accessed 25 April 2017).

International Planned Parenthood Federation (IPPF). 2017 (unpublished). *Toolkit Deliver+Enable: Scaling-up comprehensive sexuality education (CSE)*. London, IPPF.

International Planned Parenthood Federation (IPPF) and Coram Children's Legal Centre. 2014. *Inception Report: Qualitative research on legal barriers to young people's access to sexual and reproductive health services*. London, IPPF. http://www.ippf.org/resource/inception-report-qualitative-research-legal-barriers-young-peoples-access-sexual-and (Accessed 4 May 2017).

ILO, OHCHR, UNAIDS Secretariat, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, UN Women, WFP and WHO. 2015. *Joint UN statement on Ending violence and discrimination against lesbian, gay, bisexual, transgender and intersex people*. New York, United Nations. http://www.ohchr.org/Documents/Issues/Discrimination/Joint_LGBTI_Statement_ENG.PDF (Accessed 24 August 2017).

Jemmott, J. B., Jemmott, L. S., Fong, G. T. and Morales, K. H. 2010. Effectiveness of an HIV/STD risk-reduction intervention for adolescents when implemented by community-based organizations: A cluster-randomized controlled trial. *American Journal of Public Health*, 100(4), 720–726. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836337/ http://doi.org/10.2105/AJPH.2008.140657

Jennings, L., Parra-Medina, D., Hilfinger-Messias, D. and McLoughlin, K. 2006. Toward a critical social theory of youth empowerment. *Journal of Community Practice*, Vol. 14, No. 1-2, pp. 31-55.

Kennedy, A.C. and Bennett, L. 2006. Urban adolescent mothers exposed to community, family and partner violence: Is cumulative violence exposure a barrier to school performance and participation? *Journal of Interpersonal Violence*. 6, pp. 750–773.

Killermann, S. 2015. The Genderbread Person v3. [Blog] *It's Pronounced Metrosexual*. http://itspronouncedmetrosexual.com/2015/03/the-genderbread-person-v3/#sthash.F0QoolEk.dpbs (Accessed 5 February 2017).

Kirby, D. 2007. *Emerging Answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC, The National Campaign to Prevent Teen and Unplanned Pregnancy. https://thenationalcampaign.org/sites/default/files/resource-primary-download/EA2007_full_0.pdf

Kirby, D. 2009. *Recommendations for Effective Sexuality Education Programmes*. Unpublished review prepared for UNESCO. Paris, UNESCO.

Kirby, D. 2011. *Sex Education: Access and impact on sexual behaviour of young people*. United Nations Expert Group Meeting on Adolescents, Youth and Development. New York, Population Division, Department of Economic and Social Affairs, United Nations Secretariat.

Kirby, D., Korpi, M., Barth, R. P. and Cagampang, H. H. 1997. The impact of the postponing sexual involvement curriculum

among youths in California. *Family Planning Perspectives*, Vol. 29, No. 3, pp. 100-108.

Kirby, D., Laris, B. and Rolleri, L. 2005. *Impact of Sex and Sex Education Programs on Sexual Behaviors of Youth in Developing and Developed Countries*. Washington DC, Family Health International (FHI).

Kirby, D., and Lepore, G. 2007. *Sexual Risk and Protective Factors: Factors affecting teen sexual behavior, pregnancy, childbearing and sexually transmitted disease: Which are important? Which can you change?* Washington DC, National Campaign to Prevent Teen Pregnancy.

Kirby, D., Obasi, A. and Laris, B. 2006. The effectiveness of sex education and hiv education interventions in schools in developing countries. *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries* in D. Ross, B. Dick and J. Ferguson (eds.) Geneva, WHO, pp. 103-150.

Kirby, D., Rolleri, L. and Wilson, M. M. 2007. *Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programmes*. Washington, DC, Healthy Teen Network.

Kivela, J., Ketting, E. and Baltussen, R. 2013. Cost analysis of school-based sexuality education programs in six countries. *Cost Effectiveness and Resource Allocation*, 11(1), 1-7. doi:10.1186/1478-7547-11-17

Kontula, O. 2010. The evolution of sex education and students' sexual knowledge in Finland in the 2000s. *Sex Education*, Vol. 10, No. 4, pp. 373-386.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B. and Lozano, R. 2002. *World Report on Violence and Health*. Geneva, WHO. http://www.who.int/violence_injury_prevention/violence/world_report/en/introduction.pdf

Lansdown, G. 2001. *Promoting Children's Participation in Democratic Decision Making*. Florence, UNICEF. https://www.unicef-irc.org/publications/pdf/insight6.pdf (Accessed 5 February 2017).

Leijten, P., Melendez-Torres, G. J., Knerr, W., and Gardner, F. 2016. Transported versus homegrown parenting interventions for reducing disruptive child behavior: A multilevel metaregression study. *Journal of the American Academy of Child and Adolescent Psychiatry.* 55(7), 610-617. doi: http://dx.doi.org/10.1016/j.jaac.2016.05.003.

Loaiza, E. and Liang, M. 2013. *Adolescent Pregnancy: A review of the evidence*. New York, UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/ADOLESCENT%20PREGNANCY_UNFPA.pdf (Accessed 25 April 2017).

Lopez, L. M., Bernholc, A., Chen, M. and Tolley, E. 2016. School-based interventions for improving contraceptive use in adolescents. *The Cochrane Library*. doi:10.1002/14651858.CD012249

Madise, N., Zulu, E. and Ciera, J. 2007. Is poverty a driver for risky sexual behaviour? Evidence from national surveys of adolescents in four African countries. *African Journal of Reproductive Health*, Vol. 11, No. 3, p. 83. https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/reprints/AJRH.11.3.83.pdf (Accessed 5 February 2017).

McKee, A. 2014. Methodological issues in defining aggression for content analyses of sexually explicit material. *Archives of Sexual Behavior*, Vol. 44, No. 1, pp. 81-87.

Meyer, E. 2010. *Gender and Sexual Diversity in Schools*. Dordrecht, Netherlands, Springer Science+Business Media.

Michielsen, K., Chersich, M. F., Luchters, S., De Koker, P., Van Rossem, R. and Temmerman, M. 2010. Effectiveness of HIV prevention for youth in sub-Saharan Africa: Systematic review and meta-analysis of randomized and nonrandomized trials. *AIDS*, 24(8), pp. 1193-1202.

Nixon, C. 2014. Current perspectives: The impact of cyberbullying on adolescent health. *Adolescent Health, Medicine and Therapeutics*, Vol. 5, pp. 143–158.

O'Connor, C., Small, S. A. and Cooney, S. M., 4. 2007. *Program fidelity and adaptation: Meeting local needs without compromising program effectiveness*. Madison, WI, University of Wisconsin-Madison/Extension. Retrieved from http://fyi.uwex.edu/whatworkswisconsin/files/2014/04/whatworks_04.pdf

Office of the High Commissioner for Human Rights (OHCHR). 2003. *CRC General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child* (CRC). New York, UN. http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC4.pdf (Accessed 30 April 2017).

Office of the Special Advisor on Gender Issues and Advancement of Women. 2001. *Gender Mainstreaming: Strategy for promoting gender equality*. New York, Office of the Special Advisor on Gender Issues and Advancement of Women. http://www.un.org/womenwatch/osagi/pdf/factsheet1.pdf (Accessed 30 April 2017).

Ofsted 2013. *Ofsted Annual Report 2012/13: Schools report*. London, Ofsted.

Okonofua, F. 2007. New research findings on adolescent reproductive health in Africa [Nouveaux résultats de recherche sur la santé de reproduction en Afrique]. *African Journal of Reproductive Health*, Vol. 11, No. 3, p. 7.

Oosterhof, P., Muller, C. and Shephard, K. 2017. Sex education in the digital era. *IDS Bulletin,* Vol. 48, No. 1. http://bulletin.ids.ac.uk/idsbo/issue/view/223 (Accessed 30 May 2017).

Oringanje, C., Meremikwu, M. M., Eko, H., Esu, E., Meremikwu, A. and Ehiri, J. E. 2009. Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database of Systematic Reviews*, N.PAG-N.PAG. doi:10.1002/14651858.CD005215.pub2

Otieno, A. 2006. *Gender and Sexuality in the Kenyan Education System: Is history repeating itself? An exploratory study of information on sexuality within Nakuru town*. MA. Southern and Eastern African Regional Centre for Women's Law at the University of Zimbabwe.

Organisation for Economic Co-operation and Development (OECD). 2017. *Early Learning Matters*. Paris, OECD. https://www.oecd.org/edu/school/Early-Learning-Matters-Project-Brochure.pdf. (Accessed 30 April 2017).

Office of the United Nations High Commissioner for Human Rights (OHCHR) . 2016. *Living Free and Equal. What States are doing to tackle violence and discrimination against lesbian, gay, bisexual, transgender and intersex people.* New York and Geneva, United Nations.

Pan American Health Organization (PAHO) and WHO. 2000. *Promotion of Sexual Health. Recommendations for Action*. Washington D.C., PAHO.

Peter and Valkenburg. 2007. Online communication and adolescent well-being: Testing the stimulation versus the displacement hypothesis. *Journal of Computer-mediated communication*. Vol. 12, 4, pp. 1169-1182.

Plan International. 2016. *Counting the Invisible: Using data to transform the lives of girls and women by 2030*. Woking, Plan International. http://www.ungei.org/resources/files/2140_biaag_2016_english_finalv2_low_res.pdf (Accessed 30 April 2017).

Plan International. 2017. *Teenage Pregnancy.* Woking, Plan International. https://plan-international.org/sexual-health/teenage-pregnancy (Accessed May 2017).

Pound P., Denford S., Shucksmith J., Tanton C., Johnson A.M., Owen J., Hutten R., Mohan L., Bonell C., Abraham C. and Campbell R. 2017. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. *British Medical Journal Open*. 2017 Jul 2; 7(5): e014791. doi: 10.1136/bmjopen-2016-014791. http://bmjopen.bmj.com/content/bmjopen/7/5/e014791.full.pdf (Accessed 21 July 2017).

Pound, P., Langford, R., and Campbell, R. 2016. What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *British Medical Journal Open*, 6(9). doi:10.1136/bmjopen-2016-011329

Religious Institute. 2002. *Open letter to religious leaders about sex education*. http://religiousinstitute.org/wp-content/uploads/2009/06/Open-Letter-Sex-Education.pdf (Accessed 30 April 2017).

Rohleder, P. and Swartz, L. 2012. Disability, sexuality and sexual health. *Understanding Global Sexualities: New Frontiers* (Sexuality, culture and health series). 138-152. DOI: 10.4324/9780203111291

Rohrbach, L. A., Berglas, N. F., Jerman, P., Angulo-Olaiz, F., Chou, C. P. and Constantine, N. A. 2015. A Rights-Based Sexuality Education Curriculum for Adolescents: 1-Year Outcomes From a Cluster-Randomized Trial. *Journal of Adolescent Health*, 57(4), 399-406. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/910/CN-01131910/frame.htmldoi:10.1016/j.jadohealth.2015.07.004

Ross, D., Dick, B. and Ferguson, J. 2006. *Preventing HIV/AIDS in Young People: A systematic review of the evidence from developing countries*. Geneva, WHO.

Save the Children. 2015. *What do children want in times of emergency and crisis? They want an education*. London, Save the Children. https://www.savethechildren.org.uk/sites/default/files/images/What_Do_Children_Want1.pdf (Accessed 30 April 2017)

Secor-Turner, M., Schmitz, K. and Benson, K. 2016. Adolescent experience of menstruation in rural Kenya. *Nursing Research*, Vol. 65, No. 4, pp. 301-305.

Sedgh, G., Ashford, L. S. and Hussain, R. 2016. *Unmet Need for Contraception in Developing Countries: Examining women's reasons for not using a method*. New York, Guttmacher Institute. https://www.guttmacher.org/report/unmet-need-for-contraception-in-developing-countries (Accessed 30 April 2017).

Shepherd, J., Kavanagh, J., Picot, J., Cooper, K., Harden, A., Barnett-Page, E., . . . Price, A. 2010. The effectiveness and cost effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: A systematic review and economic evaluation. *Health Technology Assessment*, 14(7), 1-230.

Stead, M., Stradling, R., MacNeil, M., MacKintosh, A. and Minty, S. 2007. Implementation evaluation of the Blueprint multi-component drug prevention programme: Fidelity of school component delivery. *Drug and Alcohol Review*, Vol. 26, No. 6, pp. 653-664.

Stephenson, J., Strange, V., Forrest, S., Oakley, A., Copas, A., Allen, E., Babiker, A., Black, S., Ali, M., Monteiro, H. and Johnson, A. 2004. Pupil-led sex education in England (RIPPLE study): cluster-randomised intervention trial. *The Lancet*, Vol. 364, No. 9431, pp. 338-346.

Stirling, M., Rees, H., Kasedde, S. and Hankins, C. 2008. *Addressing the vulnerability of young women and girls to stop the HIV epidemic in Southern Africa.* Geneva, UNAIDS.

Straight Talk Foundation. 2008. *Annual Report. Kampala, Straight Talk Foundation*. https://www.scribd.com/document/17357627/Straight-Talk-Foundation-Annual-Report-2008 (Accessed 30 May 2017).

Thomas, F. and Aggleton, P. 2016. School-based sex and relationships education: Current knowledge and emerging themes. In: Sundaram, V. and Sauntson, H. (eds) *Global Perspectives and Key Debates in Sex and Relationships Education: Addressing Issues of Gender, Sexuality, Plurality and Power*. Basingstoke, Palgrave Macmillan.

Tolli, M. V. 2012. Effectiveness of peer education interventions for HIV prevention, adolescent pregnancy prevention and sexual health promotion for young people: A systematic review of European studies. *Health Education Research.* 27(5), 904-913. doi:10.1093/her/cys055

Trenholm, C., Devaney, B., Fortson, K., Quay, L., Wheeler, J. and Clark, M. 2007. *Impacts of Four Title V, Section 510 Abstinence Education Programs: Final Report*. Trenton, NJ, Mathematica Policy Research Inc.

Uganda Bureau of Statistics (UBOS) and Macro International Inc. 2007. *Uganda Demographic and Health Survey 2006*. Calverton, Md., UBOS and Macro International Inc. http://www.dhsprogram.com/pubs/pdf/FR194/FR194.pdf (Accessed 30 May 2017).

Underhill, K., Montgomery, P. and Operario, D. 2007. Sexual abstinence only programmes to prevent HIV infection in high income countries: Systematic review. *British Medical Journal*, Vol. 335, No. 7613, pp. 248-248. http://bmj.com/cgi/content/full/335/7613/248 (Accessed 13 August 2017).

United Nations. 1989. *Convention on the Rights of the Child*. New York, UN. http://www.ohchr.org/en/professionalinterest/pages/crc.aspx (Accessed 30 May 2017).

United Nations. 1995. *Platform for Action of the United Nations Fourth World Conference on Women*. New York, UN. http://www.un.org/esa/gopher-data/conf/fwcw/off/a--20.en (Accessed 30 May 2017).

United Nations. 1999. *Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development*. New York, UN. http://www.unfpa.org/sites/default/files/resource-pdf/A_S-21_AC.1_L.pdf (Accessed 30 May 2017).

United Nations. 2001. *Declaration of Commitment on HIV/AIDS*. New York, UN. http://www.unaids.org/sites/default/files/sub_landing/files/aidsdeclaration_en_0.pdf (Accessed 30 May 2017).

United Nations. 2007. *Convention of the Rights of Persons with Disabilities*. New York, UN. https://www.un.org/development/desa/disabilities/resources/general-assembly/convention-on-the-rights-of-persons-with-disabilities-ares61106.html (Accessed 30 May 2017).

United Nations. 2010. *Report of the United Nations Special Rapporteur on the Right to Education*. http://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/UNSR_Sexual_Education_2010.pdf (Accessed 30 May 2017).

United Nations. 2014. *Programme of Action adopted at the International Conference on Population and Development Cairo, 5-13 September 1994*. New York, UNFPA. http://www.unfpa.org/publications/international-conference-population-and-development-programme-action (Accessed 30 May 2017).

UNAIDS. 2006. *Scaling up Access to HIV Prevention, Treatment, Care and Support: The next steps*. Geneva, UNAIDS. http://data.unaids.org/publications/irc-pub07/jc1267-univaccess-thenextsteps_en.pdf (Accessed 30 May 2017).

UNAIDS. 2008. *2008 Report on the Global AIDS Epidemic*. Geneva, UNAIDS. http://www.unaids.org/sites/default/files/media_asset/jc1510_2008globalreport_en_0.pdf (Accessed 30 May 2017).

UNAIDS. 2012 *Factsheet on Young people, Adolescents and HIV*. Geneva, UNAIDS. http://files.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120417_FS_adolescentsyoungpeoplehiv_en.pdf (Accessed 30 May 2017).

UNAIDS 2014. *The Gap Report*. Geneva, UNAIDS. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf (Accessed 30 May 2017).

UNAIDS. 2016. *HIV Prevention among Adolescent Girls and Young Women: Putting HIV prevention among adolescent girls and young and including boys & men women on the Fast-Track and engaging men and boys*. Geneva, UNAIDS. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf

UNAIDS. 2017. *Ending AIDS. Progress towards the 90-90-90 Targets*. Global AIDS Update. Geneva, UNAIDS. http://www.unaids.org/en/resources/documents/2017/20170720_Global_AIDS_update_2017

UNAIDS and WHO. 2007. *2007 AIDS Epidemic Update*. Geneva, UNAIDS. http://data.unaids.org/pub/epislides/2007/2007_epiupdate_en.pdf (Accessed 30 May 2017).

UNDP. 2015. *Report of the Regional Dialogue on LGBTI Human Rights and Health in Asia-Pacific*. Bangkok, UNDP. http://www.asiapacific.undp.org/content/dam/rbap/docs/Research%20and%20Publications/hiv_aids/rbap-hhd-2015-report-regional-dialogue-lgbti-rights-health.pdf (Accessed 30 May 2017).

UNDP (in press). *Leave no one Behind: Advancing social, economic, cultural and political inclusion of LGBTI people in Asia and the Pacific*.

UNESCO. 1996. *Learning: The treasure within. Report to UNESCO of the International Commission on Education for the Twenty-first Century*. Paris, UNESCO. http://unesdoc.unesco.org/images/0010/001095/109590eo.pdf (Accessed 30 May 2017).

UNESCO. 2000a. *Dakar Framework for Action, Education for All. Meeting our collective commitments*. Paris, UNESCO. http://unesdoc.unesco.org/images/0012/001211/121147e.pdf (Accessed 30 May 2017).

UNESCO. 2000b. *General Comment No. 14. Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights*. Geneva, UNESCO. http://data.unaids.org/publications/external-documents/ecosoc_cescr-gc14_en.pdf (Accessed 30 May 2017) .

UNESCO. 2008. *School-centred HIV and AIDS Care and Support in Southern Africa: Technical consultation report, 22-24 May 2008, Gaborone, Botswana*. Paris, UNESCO. http://unesdoc.unesco.org/images/0015/001578/157860e.pdf (Accessed 30 May 2017).

UNESCO. 2009. *International Technical Guidance on Sexuality Education: An Evidence-informed approach for schools, teachers and health educators*. Paris, UNESCO. http://unesdoc.unesco.org/images/0018/001832/183281e.pdf (Accessed 3 May 2017).

UNESCO. 2010. *Levers of Success: Case studies of national sexuality education programmes*. Paris, UNESCO. http://unesdoc.unesco.org/images/0018/001884/188495e.pdf (Accessed 30 April 2017).

UNESCO. 2011a. *Cost and Cost-effectiveness Analysis of School-based Sexuality Education Programmes in Six Countries*. Paris, UNESCO. http://unesdoc.unesco.org/images/0021/002116/211604e.pdf

UNESCO. 2011b. *Sexuality Education Review and Assessment Tool*. Paris, UNESCO. http://hivhealthclearinghouse.unesco.org/library/ documents/sexuality-education-review-and-assessment-tool-serat-0 (Accessed 4 May 2015).

UNESCO. 2012. *Review of Policies and Strategies to Implement and Scale Up Sexuality Education in Asia and the Pacific*. Bangkok, UNESCO Bangkok. http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

UNESCO. 2013a. *Measuring the Education Sector Response to HIV and AIDS: Guidelines for the construction and use of core indicators*. Paris, UNESCO. http://unesdoc.unesco.org/images/0022/002230/223028e.pdf (Accessed 30 May 2017).

UNESCO. 2013b. *Ministerial Commitment on Comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern African (ESA)*. Paris, UNESCO. http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/ESACommitmentFINALAffirmedon7thDecember.pdf (Accessed 30 May 2017).

UNESCO. 2014a. *Comprehensive Sexuality Education: The challenges and opportunities of scaling-up*. Paris, UNESCO. http://unesdoc.unesco.org/images/0022/002277/227781e.pdf (Accessed 5 May 2017).

UNESCO. 2014b. *Good Policy and Practice in Health Education: Puberty education and menstrual hygiene management*. Paris, UNESCO. http://unesdoc.unesco.org/images/0022/002267/226792e.pdf (Accessed 3 May 2017.)

UNESCO. 2015a. *Emerging Evidence, Lessons and Practice in Global Comprehensive Sexuality Education: A global review*. Paris, UNESCO. http://www.unfpa.org/sites/default/files/pub-pdf/CSE_Global_Review_2015.pdf (Accessed 4 May 2017).

UNESCO. 2015b. *From Insult to Inclusion: Asia-Pacific report on school bullying, violence and discrimination on the basis of sexual orientation and gender identity*. Paris, UNESCO. http://unesdoc.unesco.org/images/0023/002354/235414e.pdf (Accessed 5 May 2017).

UNESCO. 2016a. *2016 Global Education Monitoring Report. Education for people and planet: Creating sustainable futures for all*. Paris, UNESCO. http://unesdoc.unesco.org/images/0024/002457/245745e.pdf (Accessed 5 May 2017).

UNESCO. 2016b. *Out in the Open: Education Sector Responses to Violence based on Sexual Orientation and Gender Identity/Expression*. Paris. UNESCO. http://unesdoc.unesco.org/images/0024/002447/244756e.pdf

UNESCO. 2016c. *Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education*; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO.

UNESCO. 2017a. *Early and Unintended Pregnancy: Recommendations for the education sector*. Paris, UNESCO. http://unesdoc.unesco.org/images/0024/002484/248418e.pdf (Accessed 30 May 2017).

UNESCO. 2017b. *Good Policy and Practice in Health Education. Booklet 10. Education sector responses to the use of alcohol, tobacco and drugs*. Paris, UNESCO. http://unesdoc.unesco.org/images/0024/002475/247509E.pdf (Accessed 30 May 2017).

UNESCO. 2017c. *Review of Curricula and Curricular Frameworks. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education: prepared by Advocates for Youth*. Paris, UNESCO.

UNESCO. 2017d. *School Violence and Bullying: Global status report*. Paris, UNESCO. http://unesdoc.unesco.org/images/0024/002469/246970e.pdf (Accessed 5 May 2017).

UNESCO and The Global Network of People Living with HIV (GNP+). 2012. *Positive Learning: Meeting the needs of young people living with HIV (YPLHIV) in the education sector*. Paris/Netherlands, UNESCO/GNP+ http://unesdoc.unesco.org/images/0021/002164/216485E.pdf (Accessed 5 May 2017).

UNESCO and UNAIDS. 2008. *EDUCAIDS Framework for Action*. Paris/Geneva, UNESCO/UNAIDS. http://unesdoc.unesco.org/images/0014/001473/147360e.pdf (Accessed 30 April 2017).

UNFPA. 2010. *Comprehensive Sexuality Education: Advancing human rights, gender, equality and improved sexual and reproductive health*. Bogota, UNFPA. https://www.unfpa.org/sites/default/files/resource-pdf/Comprehensive%20Sexuality%20Education%20Advancing%20Human%20Rights%20Gender%20Equality%20and%20Improved%20SRH-1.pdf (Accessed 3 May 2017).

UNFPA. 2013. *Adolescent Pregnancy: A review of the evidence.* New York, UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/ADOLESCENT%20PREGNANCY_UNFPA.pdf (Accessed 5 May 2017).

UNFPA. 2014. *Operational Guidance for Comprehensive Sexuality Education: A focus on human rights and gender*. New York, UNFPA. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA%20Operational%20Guidance%20for%20CSE%20-Final%20WEB%20Version.pdf (Accessed 5 May 2017).

UNFPA. 2015. *The Evaluation of Comprehensive Sexuality Programmes: A Focus on the gender and empowerment outcomes*. New York, UNFPA. https://www.unfpa.org/sites/default/files/pub-pdf/UNFPAEvaluationWEB4.pdf (Accessed 5 May 2017).

UNFPA, UNESCO and WHO. 2015. *Sexual and Reproductive Health of Young People in Asia and the Pacific: A review of issues, policies and programmes.* Bangkok, UNFPA. http://unesdoc.unesco.org/images/0024/002435/243566E.pdf (Accessed 30 April 2017).

UNICEF. 2002. *The State of the World's Children 2003*. New York, UNICEF. https://www.unicef.org/sowc03/contents/pdf/SOWC03-eng.pdf (Accessed 30 May 2017).

UNICEF. 2014a. *Ending Child Marriage: Progress and prospects.* New York, UNICEF. https://www.unicef.org/media/files/Child_Marriage_Report_7_17_LR..pdf (Accessed 5 May 2017).

UNICEF. 2014b.*Hidden in Plain Sight: A statistical analysis of violence against children*. New York, UNICEF. http://files.unicef.org/publications/files/Hidden_in_plain_sight_statistical_analysis_EN_3_Sept_2014.pdf (Accessed 5 May 2017).

USAID. 2009. *Factsheet on Youth Reproductive Health Policy: Poverty and youth reproductive health*. Washington, DC, USAID. http://pdf.usaid.gov/pdf_docs/Pnadr402.pdf (Accessed 5 May 2017).

USAID. 2013 *Getting to Zero. A discussion paper on ending extreme poverty.* Washington, USAID. https://www.usaid.gov/sites/default/files/documents/1870/USAID-Extreme-Poverty-Discussion-Paper.pdf (Accessed 3 May 2017).

Villa-Torres, L., and Svanemyr, J. 2015. Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs. *Journal of Adolescent Health*, 56(1), S51-S57. doi:10.1016/j.jadohealth.2014.07.022

Weeks, J. 2011. *The Languages of Sexuality*. Oxon, Routledge.

WHO. 2001. *Regional Strategy on Sexual and Reproductive Health*. Copenhagen, WHO, Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0004/69529/e74558.pdf (Accessed 31 May 2017).

WHO. 2002. *Defining Sexual Health: Report of a technical consultation on sexual health.* Geneva, WHO. http://www.who.int/reproductivehealth/topics/gender_rights/defining_sexual_health.pdf (Accessed 31 May 2017).

WHO. 2003. *Skills for Health. Skills-based health education including life skills: An important component of a child-friendly/health-promoting school*. Geneva, WHO. http://www.who.int/school_youth_health/media/en/sch_skills4health_03.pdf (Accessed 31 May 2017).

WHO. 2004. *Adolescent Pregnancy: Issues in adolescent health and development*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/42903/1/9241591455_eng.pdf (Accessed 5 May 2017).

WHO. 2005. *Sexually Transmitted Infections among Adolescents. The need for adequate health services*. Geneva, WHO. http://www.who.int/maternal_child_adolescent/documents/9241562889/en/ (Accessed 5 May 2017).

WHO. 2006a. *Defining Sexual Health: Report of a technical consultation on sexual health, 28–31 January 2002*. Geneva, WHO. http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/ (Accessed 5 May 2017).

WHO. 2006b. *Pregnant Adolescents: Delivering on global promises of hope*. Geneva, WHO. http://www.youthnet.org.hk/adh/2_AD_sexual_reproductiveH/Adolescent_Pregnancy/WHO%20-%20Pregnant%20Adolescents.pdf (Accessed 30 May 2017).

WHO. 2007a. *Unsafe Abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003*, 5th edn. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/43798/1/9789241596121_eng.pdf (Accessed 5 May 2017).

WHO 2007b. *Adolescent Pregnancy - Unmet needs and undone deeds: A review of the literature and programmes*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/43702/1/9789241595650_eng.pdf (Accessed 5 May 2017).

WHO. 2008. *Pregnant Adolescents: Delivering on Global Promises*. Geneva, WHO. http://www.youthnet.org.hk/adh/2_AD_sexual_reproductiveH/Adolescent_Pregnancy/WHO%20-%20Pregnant%20Adolescents.pdf (Accessed 30 May 2017).

WHO. 2010. *The ASSIST-linked Brief Intervention for Hazardous and Harmful Substance Use: Manual for use in primary care*. Manual 1. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/44320/1/9789241599382_eng.pdf (Accessed 30 May 2017).

WHO. 2011. *WHO Guidelines on Preventing Early Pregnancy and Poor Reproductive Outcomes Among Adolescents in Developing Countries*. Geneva, WHO. http://www.who.int/immunization/hpv/target/preventing_early_pregnancy_and_poor_reproductive_outcomes_who_2006.pdf (Accessed 5 May 2017).

WHO. 2014a. *Adolescent Pregnancy Factsheet*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/112320/1/WHO_RHR_14.08_eng.pdf (Accessed 30 May 2017).

WHO. 2014b. *World Health Statistics 2014*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/112738/1/9789240692671_eng.pdf?ua=1 (Accessed 30 May 2017).

WHO. 2015. *Every Woman, Every Child, Every Adolescent: Achievements and prospects*. The final report of the independent Expert Review Group on Information and Accountability for Women's and Children's health. Geneva, WHO.

WHO. 2016a. *Global Health Estimates 2015: Deaths by cause, age, sex, by country and by region, 2000-2015*. Geneva, WHO. http://www.who.int/healthinfo/global_burden_disease/en/

WHO. 2016b. *Violence against Women: Intimate Partner and Sexual Violence Against Women Factsheet*. Geneva, WHO. http://www.who.int/mediacentre/factsheets/fs239/en/ (Accessed 5 May 2017).

WHO. 2016c. *Youth Violence factsheet*. Geneva, WHO. http://www.who.int/mediacentre/factsheets/fs356/en/ (Accessed 5 May 2017).

WHO. 2017a. *Female Genital Mutilation Factsheet*. Geneva, WHO. http://who.int/mediacentre/factsheets/fs241/en/ (Accessed 30 May 2017).

WHO. 2017b. *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation - summary*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/255418/1/WHO-FWC-MCA-17.05-eng.pdf?ua=1 (Accessed 30 May 2017).

WHO and UNAIDS. 2009. *Operational Guidance for Scaling Up Male Circumcision Services for HIV Prevention*. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/44021/1/9789241597463_eng.pdf (Accessed 5 May 2017).

WHO and UNICEF. 2008. *More Positive Living: Strengthening the health sector response to young people living with HIV*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/43957/1/9789241597098_eng.pdf (Accessed 5 May 2017).

WHO and UNFPA. 2006. *Married Adolescents: No place of safety*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/43369/1/9241593776_eng.pdf (Accessed 30 April 2017).

WHO, UNFPA and UNICEF. 1999. *Programming for Adolescent Health and Development*. Geneva, WHO. http://apps.who.int/iris/bitstream/10665/42149/1/WHO_TRS_886_(p1-p144).pdf (Accessed 5 May 2017).

WHO Regional Office for Europe and Die Bundeszentrale fur gesundheitliche Aufklarung (BZgA). 2010. *Standards for Sexuality Education in Europe: A framework for policy makers, educational and health authorities and specialists*. Cologne, BZgA. http://www.oif.ac.at/fileadmin/OEIF/andere_Publikationen/WHO_BZgA_Standards.pdf (Accessed 5 May 2017).

Wight, D. 2011. The effectiveness of school-based sex education: What do rigorous evaluations in Britain tell us? *Education and Health*, 29(4), 72-78.

Women's Refugee Commission, Save the Children, UNHCR, UNFPA. 2012. *Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services.* New York, UNFPA. https://www.unfpa.org/sites/default/files/resourcepdf/AAASRH_good_practice_documentation_English_FINAL.pdf (Accessed 30 April 2017).

Woog V., Singh, S.S, Browne, A. and Philbin, J. 2015. *Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries*. New York, Guttmacher Institute. http://www.guttmacher.org/pubs/Adolescent-SRHS-Need-Developing-Countries.pdf. (Accessed 30 May 2017).

9

Glossary

9 - Glossary

The terms and concepts used in this document reflect widely accepted definitions, as well as definitions used in documents prepared by the United Nations Educational, Scientific and Cultural Organization (UNESCO) and other United Nations (UN) agencies.

Definitions for common terms and concepts used in this document include:

Adolescent: a person aged 10 to 19 years, as defined by the UN.

Bisexual: a person who is attracted to people of more than one gender.

Bullying: behaviour repeated over time that intentionally inflicts injury or discomfort through physical contact, verbal attacks, or psychological manipulation. Bullying involves an imbalance of power.

Child: a person under 18 years of age, as defined by the UN.

Coercion: the action or practice of persuading someone to do something by using force or threats.

Curriculum: a curriculum addresses questions such as what students of different ages should learn and be able to do, why, how and how well.

Cyberbullying: the use of electronic communication to bully a person, typically by sending messages of an intimidating or threatening nature.

Discrimination: any unfair treatment or arbitrary distinction based on a person's race, sex, religion, nationality, ethnic origin, sexual orientation, disability, age, language, social origin or other status.

Equity: fair and impartial treatment, including equal treatment or differential treatment to redress imbalances in rights, benefits, obligations and opportunities.

Gay: A person who is primarily attracted to and/or has relationships with someone of the same gender. Commonly used for men, some women also use this term.

Gender: Refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes.

Gender norms or roles: Gender attributes, opportunities and relationships between women and men, boys and girls or other gender identities vary from society to society, can change over time, and are learned through socialization processes around culturally expected, allowed or valued behaviours on what to do and how to be in relation to gender. Rigid, discriminatory gender conceptions can lead to inequality and harmful practices defended on the basis of tradition, culture, religion or superstition.

Gender expression: how a person expresses their own gender to the world, for example, through their name, clothes, how they walk, speak, communicate, societal roles and their general behaviour.

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 the personal sense of the body which may involve, if freely chosen, modification of bodily appearance or function (by medical, surgical or other means).

Gender non-conformity/non-conforming: people who do not conform to either of the binary gender definitions of male or female, as well as those whose gender expression may differ from standard gender norms. In some instances, individuals are perceived by society as gender non-conforming because of their gender expression. However, these individuals may not perceive themselves as gender non-conforming. Gender expression and gender non-conformity are clearly related to individual and social perceptions of masculinity and femininity.

Gender variance: expressions of gender that do not match those predicted by one's assigned sex at birth.

Gender-based violence: violence against someone based on gender discrimination, 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.

Harassment: any improper and unwelcome conduct that might reasonably be expected or be perceived to cause offence or humiliation to another person. Harassment may take the form of words, gestures or actions that tend to annoy, alarm, abuse, demean, intimidate, belittle, humiliate or embarrass another person; or that create an intimidating, hostile or offensive environment.

Heteronormativity: the belief that heterosexuality is the normal or default sexual orientation.

Homophobia: the fear, discomfort, intolerance or hatred of homosexuality and people based on their real or perceived sexual orientation.

Homophobic violence: a gendered type of bullying that is based on actual or perceived sexual orientation.

Homosexual: a person who is physically, emotionally and/or sexually attracted to people of the same sex.

Inclusive education: the process of strengthening the capacity of the education system to reach out to all learners.

Informed consent: the process for getting voluntary agreement to participate in research or an intervention.

Intersex: people who are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies. 'Intersex' is an umbrella term used to describe a wide range of natural bodily variations. In some cases, intersex traits are visible at birth, while in others they are not apparent until puberty. Some chromosomal intersex variations may not be physically apparent at all. Being intersex relates to biological sex characteristics and is distinct from a person's sexual orientation or gender identity. An intersex person may be straight, gay, lesbian or bisexual, and may identify as female, male, both or neither.

Lesbian: a woman who experiences physical, emotional and/or sexual attraction to, and the capacity for an intimate relationship, primarily, with other women.

Pedagogy: the way that educational content is delivered, including the use of various methodologies that recognize that individuals learn in different ways and help different children engage with educational content and learn more effectively.

Reproductive health: a state of complete physical, mental and social well-being in all matters relating to the reproductive system, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and systems at all stages of life, and implies that people are able to have a satisfying and safe sex life, the capacity to reproduce and the freedom to decide if, when and how often to do so.

Reproductive rights: embrace human rights recognized in national laws, international human rights documents and other consensus documents, and are 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, education and the means to do so, and the right to the highest attainable standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents (see *Appendix I*).

School-related gender-based violence: 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.

Sex: Biological and physiological characteristics (genetic, endocrine, and anatomical) used to categorize people as members of either the male or female population (see also the definition of intersex).

Sexual health: a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual orientation: Each person's capacity for profound emotional, affectional, and sexual attraction to, and intimate and sexual relations with, individuals of a different gender (heterosexual) or the same gender (homosexual) or more than one gender (bisexual or pansexual).

Stigma: opinions or judgements held by individuals or society that negatively reflect on a person or group. Discrimination occurs when stigma is acted on.

Transgender: a person whose internal sense of their gender (gender identity) differs from their sex assigned at birth. Transgender people may be heterosexual, homosexual or bisexual. Transgender people may identify as male or as female or with an alternate gender, a combination of genders or no gender.

Transsexual: The term 'transsexual' is sometimes used to describe transgender people who have undergone or want to undergo medical procedures (which may include surgical and hormonal treatment) to make their body more congruent with their gender identity.

Transphobia: the fear, discomfort, intolerance or hatred of transgender people.

Transphobic violence: a gendered type of violence that is based on actual or perceived gender identity.

Violence: any action, explicit or symbolic, which results in, or is likely to result in, physical, sexual or psychological harm.

Young person: a person between 10 and 24 years old, as defined by the UN.

Youth: a person between 15 and 24 years old, as defined by the UN. The UN uses this age range for statistical purposes, but respects national and regional definitions of youth.

Monkey Business Images /Shutterstock.com

10

Appendices

10 - Appendices

Appendix I
International agreements, instruments and standards related to comprehensive sexuality education (CSE)

Relevant paragraphs from international agreements, instruments and standards that are of relevance to comprehensive sexuality education are quoted below:

Transforming our world: the 2030 Agenda for Sustainable Development (A/RES/70/1) Political Declaration including the Sustainable Development Goals (SDGs), 2015

19. We reaffirm the importance of the Universal Declaration of Human Rights, as well as other international instruments relating to human rights and international law. We emphasize the responsibilities of all States, in conformity with the Charter of the United Nations, to respect, protect and promote human rights and fundamental freedoms for all, without distinction of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status.

20. Realizing gender equality and the empowerment of women and girls will make a crucial contribution to progress across all the Goals and targets. The achievement of full human potential and of sustainable development is not possible if one half of humanity continues to be denied its full human rights and opportunities. Women and girls must enjoy equal access to quality education, economic resources and political participation as well as equal opportunities with men and boys for employment, leadership and decision-making at all levels. We will work for a significant increase in investments to close the gender gap and strengthen support for institutions in relation to gender equality and the empowerment of women at the global, regional and national levels. All forms of discrimination and violence against women and girls will be eliminated, including through the engagement of men and boys. The systematic mainstreaming of a gender perspective in the implementation of the Agenda is crucial.

25. We commit to providing inclusive and equitable quality education at all levels – early childhood, primary, secondary, tertiary, technical and vocational training. All people, irrespective of sex, age, race or ethnicity, and persons with disabilities, migrants, indigenous peoples, children and youth, especially those in vulnerable situations, should have access to life-long learning opportunities that help them to acquire the knowledge and skills needed to exploit opportunities and to participate fully in society. We will strive to provide children and youth with a nurturing environment for the full realization of their rights and capabilities, helping our countries to reap the demographic dividend, including through safe schools and cohesive communities and families.

26. To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education.

Sustainable Development Goals (SDGs)

SDG3: Ensure healthy lives and promote well-being for all at all ages

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

SDG4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes

4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development

SDG5: Achieve gender equality and empower all women and girls

5.1 End all forms of discrimination against all women and girls everywhere

5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

5.6 Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

SDG10: Reduce inequality within and among countries

10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard

SDG16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

16.1 Significantly reduce all forms of violence and related death rates everywhere
16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children
16.b Promote and enforce non-discriminatory laws and policies for sustainable development

Education 2030 Incheon Declaration and Framework for Action for the implementation of Sustainable Development Goal 4. Towards inclusive and equitable quality education and lifelong learning for all 2015. World Education Forum

Comprehensive sexuality education is listed in relation to education for sustainable development (ESD) and global citizenship education (GCED). Thematic Indicators to Monitor the Education 2030 Agenda. Indicator for SDG target 4.7: 28. (p. 79): "Percentage of schools that provide life skills-based HIV and sexuality education".

63. Indicative strategies: Develop policies and programmes to promote ESD and GCED and bring them into the mainstream of formal, non-formal and informal education through system-wide interventions, teacher training, curricular reform and pedagogical support. This includes implementing the Global Action Programme on ESD* and addressing themes such as human rights, gender equality, health, comprehensive sexuality education, climate change, sustainable livelihoods and responsible and engaged citizenship, based on national experiences and capabilities.

Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, 2016 (A/RES/70/266)

41. Remain deeply concerned that, globally, women and girls are still the most affected by the epidemic and that they bear a disproportionate share of the caregiving burden, note that progress towards gender equality and the empowerment of all women and girls has been unacceptably slow and that the ability of women and girls to protect themselves from HIV continues to be compromised by physiological factors, gender inequalities, including unequal power relations in society between women and men and boys and girls, and unequal legal, economic and social status, insufficient access to health-care services, including sexual and reproductive health, and all forms of discrimination and violence in the public and private spheres, including trafficking in persons, sexual violence, exploitation and harmful practices;

61. (c) Pledge to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence, in order to increase their ability to protect themselves from HIV infection, and take all necessary measures to create an enabling environment for the empowerment of women and to strengthen their economic independence, and, in this context, reiterate the importance of the role of men and boys in achieving gender equality;

62. (c) Commit to accelerating efforts to scale up scientifically accurate age-appropriate comprehensive education, relevant to cultural contexts, that provides adolescent girls and boys and young women and men, in and out of school, consistent with their evolving capacities, with information on sexual and reproductive health and HIV prevention, gender equality and women's empowerment, human rights, physical, psychological and pubertal development and power in relationships between women and men, to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships, in full partnership with young persons, parents, legal guardians, caregivers, educators and health-care providers, in order to enable them to protect themselves from HIV infection;

* Endorsed by the UNESCO General Conference (37C/Resolution 12) and acknowledged by the UN General Assembly (A/RES/69/211) as follow up to the UN Decode of ESD.

Human Rights Instruments, Covenants and Standards:

1 The Universal Declaration of Human Rights (1948)

2 Convention on the Elimination of All forms of Discrimination against Women (CEDAW 1979)

3 Convention on the Rights of the Child (1989/90)

4 International Covenant on Economic, Social and Cultural Rights (1966/76)

5 The Convention on the Rights of Persons with disabilities (2006)

Human Rights Council: Accelerating efforts to eliminate violence against women: engaging men and boys in preventing and responding to violence against all women and girls. A/HRC/35/L.15 2017

(g) Developing and implementing educational programmes and teaching materials, including comprehensive sexuality education, based on full and accurate information, for all adolescents and youth, in a manner consistent with their evolving capacities, with appropriate direction and guidance from parents and legal guardians, with the active involvement of all relevant stakeholders, in order to modify the social and cultural patterns of conduct of men and women of all ages, to eliminate prejudices and to promote and build decision-making, communication and risk reduction skills for the development of respectful relationships based on gender equality and human rights, as well as teacher education and training programmes for both formal and non-formal education.

Human Rights Council: Accelerating efforts to eliminate violence against women: preventing and responding to violence against women and girls, including indigenous women and girls A/HRC/32/L.28/Rev.1, 2016

7 (c) Taking measures to empower women by, inter alia, strengthening their economic autonomy and ensuring their full and equal participation in society and in decision-making processes by adopting and implementing social and economic policies that guarantee women full and equal access to quality education, including comprehensive sexuality education, and training, and affordable and adequate public and social services, as well as full and equal access to financial resources and decent work, and full and equal rights to own and to have access to and control over land and other property, and guaranteeing women's and girls' inheritance rights.

Committee on Economic, Social and Cultural Rights General Comment No. 22 on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) 2016

II. 5.The right to sexual and reproductive health entails a set of freedoms and entitlements. The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, over matters concerning one's body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health under article 12 of the Covenant.

II.6. Sexual health and reproductive health are distinct from, but closely linked, to each other. Sexual health, as defined by WHO, is 'a state of physical, emotional, mental and social well-being in relation to sexuality. 'Reproductive health, as described in the ICPD Programme of Action, concerns the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour.

9. The realization of the right to sexual and reproductive health requires that States parties also meet their obligations under other provisions of the Covenant. For example, the right to sexual and reproductive health, combined with the right to education (articles 13 and 14) and the right to non-discrimination and equality between men and women (articles 2 (2) and 3), entails a right to education on sexuality and reproduction that is comprehensive, non-discriminatory, evidence-based, scientifically accurate and age appropriate.

28. The realization of women's rights and gender equality, both in law and in practice, requires repealing or reforming the discriminatory laws, policies and practices in the area of sexual and reproductive health. Removal of all barriers interfering with women's access to comprehensive sexual and reproductive health services, goods, education and information is required. To lower rates of maternal mortality and morbidity requires emergency obstetric care and skilled birth attendance, including in rural and remote areas, and prevention of unsafe abortions. Preventing unintended pregnancies and unsafe abortions requires States to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents, liberalize restrictive abortion laws, guarantee women and girls access to safe abortion services and quality post-abortion care including by training health care providers, and respect women's right to make autonomous decisions about their sexual and reproductive health.

Committee on the Rights of the Child CRC/C/GC/20, General comment No. 20) on the implementation of the rights of the child during adolescence 2016

33. Adolescents who are lesbian, gay, bisexual, transgender and intersex commonly face persecution, including abuse and violence, stigmatization, discrimination, bullying, exclusion from education and training, as well as a lack of family and social support, or access to sexual and reproductive health services and information. In extreme cases, they face sexual assault, rape and even death. These experiences have been linked to low self- esteem, higher rates of depression, suicide and homelessness.

59. The Committee urges States to adopt comprehensive gender and sexuality-sensitive sexual and reproductive health policies for adolescents, emphasizing that unequal access by adolescents to such information, commodities and services amounts to discrimination. Lack of access to such services contributes to adolescent girls being the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth. All adolescents should have access to free, confidential, adolescent-responsive and non- discriminatory sexual and reproductive health services, information and education, available both online and in person, including on family planning, contraception, including emergency contraception, prevention, care and treatment of sexually transmitted infections, counselling, pre-conception care, maternal health services and menstrual hygiene.

60. There should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization. In addition, particular efforts need to be made to overcome barriers of stigma and fear experienced by, for example, adolescent girls, girls with disabilities and lesbian, gay, bisexual, transgender and intersex adolescents, in gaining access to such services. The Committee urges States to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions.

61. Age-appropriate, comprehensive and inclusive sexual and reproductive health education, based on scientific evidence and human rights standards and developed with adolescents, should be part of the mandatory school curriculum and reach out-of-school adolescents. Attention should be given to gender equality, sexual diversity, sexual and reproductive health rights, responsible parenthood and sexual behaviour and violence prevention, as well as to preventing early pregnancy and sexually transmitted infections. Information should be available in alternative formats to ensure accessibility to all adolescents, especially adolescents with disabilities.

Human Rights Council: Protection against violence and discrimination based on sexual orientation and gender identity A/HRC/32/L.2/Rev.1 (2016)

1. Reaffirms that all human beings are born free and equal in dignity and rights, and that everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status;

2. Strongly deplores acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation or gender identity.

Human Rights Council: Human rights, sexual orientation and gender identity (after gender identity) A/HRC/27/L.27/Rev.1 (2014)

Expressing grave concern at acts of violence and discrimination, in all regions of the world, committed against individuals because of their sexual orientation and gender identity,

Welcoming positive developments at the international, regional and national levels in the fight against violence and discrimination based on sexual orientation and gender identity.

CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health) Adopted at the Twentieth Session of the Committee on the Elimination of Discrimination against Women, in 1999 (Contained in Document A/54/38/Rev.1, chap. I)

18. In particular, States parties should ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programmes that respect their right to privacy and confidentiality.

23. Particular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning.* (* Health education for adolescents should further address, inter alia, gender equality, violence, prevention of sexually transmitted diseases and reproductive and sexual health rights.)

31. (b) Ensure the removal of all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and, in particular, allocate resources for programmes directed at adolescents for the prevention and treatment of sexually transmitted diseases, including HIV/AIDS.

The Convention on the Rights of Persons with disabilities (2006)

Article 5, Equality and non-discrimination: 1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law. 2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds;

Article 24, Education: 1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to: (a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity.

Beijing Declaration and Platform for Action, the Fourth World Conference on Women, 1995 and the outcome documents of its review conferences

Resolution 60/2 Women, the girl child and HIV and AIDS. The Commission on the Status of Women E/CN.6/2016/22 2016

9. Urges governments to eliminate gender inequalities and gender-based abuse and violence, increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health care, as well as full access to comprehensive information and education, ensure that women can exercise their right to have control over, and decide freely and responsibly on, matters related to their sexuality, including their sexual and reproductive health, free of coercion, discrimination and violence, in order to increase their ability to protect themselves from HIV infection, and take all necessary measures to create an enabling environment for the empowerment of women and strengthen their economic independence and, in that context, reiterates the importance of the role of men and boys in achieving gender equality;

11. Calls upon governments to accelerate efforts to scale up scientifically accurate age-appropriate comprehensive education, relevant to cultural contexts, that provides adolescent girls and boys and young women and men, in and out of school, consistent with their evolving capacities, with information on sexual and reproductive health and HIV prevention, gender equality and women's empowerment, human rights, physical, psychological and pubertal development and power in relationships between women and men, to enable them to build self-esteem, informed decision-making, communication and risk reduction skills and develop respectful relationships, in full partnership with young persons, parents, legal guardians, caregivers, educators and health-care providers, in order to enable them to protect themselves from HIV infection.

Challenges and achievements in the implementation of the Millennium Development Goals for women and girls, Commission on the Status of Women, Agreed Conclusions 2014

(o) Ensure the promotion and protection of the human rights of all women and their sexual and reproductive health, and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development, the Beijing Platform for Action and the outcome documents of their review conferences, including through the development and enforcement of policies and legal frameworks and the strengthening of health systems that make universally accessible and available quality comprehensive sexual and reproductive health-care services, commodities, information and education, including, inter alia, safe and effective methods of modern contraception, emergency contraception, prevention programmes for adolescent pregnancy, maternal health care such as skilled birth attendance and emergency obstetric care which will reduce obstetric fistula and other complications of pregnancy and delivery, safe abortion where such services are permitted by national law, and prevention and treatment of reproductive tract infections, sexually transmitted infections, HIV, and reproductive cancers, recognizing that human rights include the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free from coercion, discrimination and violence;

x) Develop and implement educational programmes and teaching materials, including comprehensive evidence-based education for human sexuality, based on full and accurate information, for all adolescents and youth, in a manner consistent with their evolving capacities, with the appropriate direction and guidance from parents and legal guardians, with the involvement of children, adolescents, youth and communities and in coordination with women's, youth and specialized non-governmental organizations, in order to modify the social and cultural patterns of conduct of men and women of all ages, to eliminate prejudices and to promote and build informed decision-making, communication and risk reduction skills for the development of respectful relationships and based on gender equality and human rights, as well as teacher education and training programmes for both formal and non-formal education.

International Conference on Population and Development (ICPD) Programme of Action (PoA), the key actions for its further implementation and the outcome documents of its review conferences

Resolution 2014/1, Assessment of the status of implementation of the Programme of Action of the International Conference on Population and Development, The Commission on Population and Development, 2014

11. Urges Governments, the international community and all other relevant stakeholders to give particular attention to the areas of shortfall in the implementation of the Programme of Action, including, the elimination of preventable maternal morbidity and mortality through strengthening health systems, equitable and universal access to quality, integrated and comprehensive sexual and reproductive health services, and by ensuring the access of adolescents and youth to full and accurate information and education on sexual and reproductive health, including evidence-based comprehensive education on human sexuality, and promotion, respect, protection and fulfilment of all human rights, especially the human rights of women and girls, including sexual and reproductive health and reproductive rights, and by addressing the persistence of discriminatory laws and the unfair and discriminatory application of laws.

Resolution 2012/1 Adolescents and youth. The Commission on Population and Development, (2012)

26. Calls upon Governments, with the full involvement of young people and with the support of the international community, to give full attention to meeting the reproductive health-service, information and education needs of young people, with full respect for their privacy and confidentiality, free of discrimination, and to provide them with evidence-based comprehensive education on human sexuality, sexual and reproductive health, human rights and gender equality to enable them to deal in a positive and responsible way with their sexuality.

ICPD + 5 (1999)

63. (i) In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public-health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can be determined only at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions; (ii) Governments should take appropriate steps to help women to avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion; (iii) In recognizing and implementing the above, and in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health.

Regional references

Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African (ESA), (2013)

3.0 Based on the above considerations, we the ministers of education and health, will lead by bold actions to ensure quality comprehensive sexuality education and youth-friendly sexual and reproductive health services in the ESA region. Specifically, we commit to:

3.1 Work together on a common agenda for all adolescents and young people to deliver comprehensive sexuality education and youth-friendly SRH services that will strengthen our national responses to the HIV epidemic and reduce new HIV/STI infections, early and unintended pregnancy and strengthen care and support, particularly for those living with HIV. Establish inter-sectoral coordination mechanisms led through the existing regional economic communities, EAC, SADC and ECSA. Where such mechanisms already exist they must be strengthened and supported.

3.5 Initiate and scale up age-appropriate CSE during primary school education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases. Using agreed international standards, ensure that CSE is age, gender and culturally appropriate, rights-based and includes core elements of knowledge, skills and values as preparation for adulthood: decisions about sexuality, relationships, gender equality, sexual and reproductive health and citizenship. Wherever possible, make in-school CSE programmes intra-curricular and examinable.

3.6 Ensure that the design and delivery of CSE and SRH programmes includes ample participation by communities and families - particularly adolescents, young people, civil society and other community structures including faith-based organisations. At the same time, adolescents and young people should be guaranteed safe spaces, the right to be their own advocates and agents of change in their own communities, and to recommend good practices and innovations which meet their needs.

3.7 Integrate and scale up youth-friendly HIV and SRH services that take into account social and cultural contexts to improve age-appropriate access to and uptake of high quality SRH services and commodities, including condoms, contraception, HPV vaccine, HIV counselling and testing (HCT), HIV/STI treatment and care, family planning, safe abortion (where legal), post abortion care, safe delivery, prevention of mother-to-child transmission (PMTCT) and other related services for young people in and out of school.

3.9 Strengthen gender equality and rights within education and health services including measures to address sexual and other forms of violence, abuse and exploitation in and around school and community contexts whilst ensuring full and equal access to legal and other services for boys and girls, young men and women.

First session of the Regional Conference on Population and Development in Latin America and the Caribbean Full integration of population dynamics into rights-based sustainable development with equality: key to the Cairo Programme of Action beyond 2014 (Montevideo Consensus on Population and Development), UNECLAC (2013)

11. Ensure the effective implementation from early childhood of comprehensive sexuality education programmes, recognizing the emotional dimension of human relationships, with respect for the evolving capacity of boys and girls and the informed decisions of adolescents and young people regarding their sexuality, from a participatory, intercultural, gender-sensitive, and human rights perspective;

12. Implement comprehensive, timely, good-quality sexual health and reproductive health programmes for adolescents and young people, including youth-friendly sexual health and reproductive health services with a gender, human rights, intergenerational and intercultural perspective, which guarantee access to safe and effective modern contraceptive methods, respecting the principles of confidentiality and privacy, to enable adolescents and young people to exercise their sexual rights and reproductive rights, to have a responsible, pleasurable and healthy sex life, avoid early and unwanted pregnancies, the transmission of HIV and other sexually transmitted infections, and to take free, informed and responsible decisions regarding their sexual and reproductive life and the exercise of their sexual orientation;

14. Prioritize the prevention of pregnancy among adolescents and eliminate unsafe abortion through comprehensive education on emotional development and sexuality, and timely and confidential access to good-quality information, counselling, technologies and services, including emergency oral contraception without a prescription and male and female condoms.

Addis Ababa Declaration on Population and Development in Africa Beyond 2014 (2013)

40. Adopt and implement relevant comprehensive sexuality education programmes, both in and out of school, that are linked to sexual and reproductive health services, with the active involvement of parents, community, traditional, religious and opinion leaders; and young people themselves.

The Sixth Asian and Pacific Population Conference (APPC) ICPD Review (2013)

59. Noting that evidence-based comprehensive sexuality education and life skills, which are consistent with evolving capacities and are age appropriate, are essential for adolescents and young people to be able to make responsible and informed decisions and exercise their right to control all aspects of their sexuality, protect themselves from unintended pregnancy, unsafe abortion, HIV and sexually transmitted infections, to promote values of tolerance, mutual respect and non-violence in relationships, and to plan their lives, while recognizing the role and responsibilities of parents, as well as of teachers and peer educators, to support them in doing so;

113. Prioritize the provision of free education for girls at all levels, access to sexual and reproductive health information services and efforts to eliminate early and forced marriage;

146. Design, ensure sufficient resources and implement comprehensive sexuality education programmes that are consistent with evolving capacities and are age appropriate, and provide accurate information on human sexuality, gender equality, human rights, relationships, and sexual and reproductive health, while recognizing the role and responsibilities of parents.

Appendix II
List of participants in the Comprehensive Sexuality Education Advisory Group, 2016-2017

Name	Organization
Qadeer BAIG	Rutgers WPF (former)
Doortje BRAEKEN	International Planned Parenthood Federation (IPPF) (former)
Shanti CONLY	United States Agency for International Development (USAID) (former)
Esther CORONA	World Association of Sexology
Helen CAHILL	University of Melbourne
Pia ENGSTRAND	Swedish International Development Cooperation Agency (Sida)
Nyaradzayi GUMBONZVANDA	Rozaria Memorial Trust; African Union Goodwill Ambassador on Ending Child Marriage
Nicole HABERLAND	Population Council
Wenli LIU	Beijing Normal University
Anna-Kay MAGNUS-WATSON	Ministry of Education, Jamaica
Peter MLADENHOV	Y-Peer
Sanet STEENKAMP	Ministry of Education, Namibia
Remmy SHAWA	Sonke Gender Justice (former)
Aminata TRAORÉ SECK	Ministry of Education, Senegal
Alice WELBOURN	Salamander Trust
Christine WINKELMANN	Die Bundeszentrale für gesundheitliche Aufklärung (BZgA)
UN Partners:	
UNAIDS	Aurelie ANDRIAMIALISON, Kreena GOVENDER, Hege WAGAN
UNDP	Caitlin BOYCE, Natalia LINOU, Suki BEAVERS
UNFPA	Ilya ZHUKOV, Maria BAKAROUDIS, Elizabeth BENOMAR
UNICEF	Susan KASEDDE, Abdelkader BACHA, Vivian LOPEZ, Myungsoo CHO, Sudha Balakrishnan
UN Women	Nazneen DAMJI, Elena KUDRAVTSEVA
WHO	Venkatraman CHANDRA-MOULI
UNESCO	Chris CASTLE, Joanna HERAT, Jenelle BABB, Karin NILSSON, Christophe CORNU, Yong Feng LIU, Xavier HOSPITAL, Patricia MACHAWIRA, Mary Guinn DELANEY, Tigran YEPOYAN, Hongyan LI, Alice SAILI

Appendix III
List of participants in the UNESCO Stakeholder Consultation and Advisory Group meeting

Consultation on updating International technical guidance on sexuality education (ITGSE)

25-27 October 2016

UNESCO International Institute for Educational Planning, Paris, France

Maria-Antonieta Alcalde
International Planned Parenthood Federation/Western Hemisphere Region (IPPF/ WHR)
United States of America

Aurelie Andriamialison
Joint United Nations Programme on HIV and AIDS (UNAIDS)
Switzerland

Ben Aliwa
Save the Children
Republic of South Africa

Jenelle Babb
United Nations Educational, Scientific and Cultural Organization (UNESCO)
France

Qadeer Baig
Rutgers WPF
Pakistan

Maria Bakaroudis
United Nations Population Fund (UNFPA)
East and Southern Africa

Diane Bernard
University of Oxford
United Kingdom of Great Britain and Northern Ireland

Margaret Bolaji
Population and Reproductive Health Initiative
Nigeria

Elisa Bonilla-Ruis
Secretaria de Education
Mexico

Doortje Braeken
International Planned Parenthood Federation (IPPF)
United Kingdom of Great Britain and Northern Ireland

Helen Cahill
University of Melbourne
Australia

Chris Castle
United Nations Educational, Scientific and Cultural Organization (UNESCO)
France

Nicole Cheetham
Advocates for Youth
United States of America

Christophe Cornu
United Nations Educational, Scientific and Cultural Organization (UNESCO)
France

Esther Corona
World Association for Sexual Health (WAS)
Mexico

Nazneen Damji
The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women)
United States of America

Mary Guinn Delaney
United Nations Educational, Scientific and Cultural Organization (UNESCO)
Chile

Stephanie Dolata
United Nations Educational, Scientific and Cultural Organization (UNESCO)
International Institute for Educational Planning
France

Pia Engstrand
Swedish International Development Cooperation (SIDA)
Sweden

Eleonor Faur
Universidad National, San Martin
Argentina

Iehente Foote
Global Youth Coalition
Canada

Hayley Gleeson
International Planned Parenthood Federation (IPPF)
United Kingdom of Great Britain and Northern Ireland

Nyaradzayi Gumbonzvanda
Rozaria Memorial Trust (former World YWCA)
Zimbabwe

Nicole Haberland
Population Council
United States of America

Joanna Herat
United Nations Educational, Scientific and Cultural Organization (UNESCO)
France

Xavier Hospital
United Nations Educational, Scientific and Cultural Organization (UNESCO)
Senegal

Alan Jarandilla Nuñez
The PACT, Youth Coalition
Bolivia (Plurinational State of)

Temir Kalbaev
Kyrgz Indigo
Kyrgyzstan

Jane Kato-Wallace
Promundo
Cabo Verde

Jean Kemitare
Raising Voices
Uganda

Sarah Keogh
Guttmacher Institute
United States of America

Evert Kettering
Independent Consultant
The Netherlands

Thanomklang Kornkaew
Minitry of Education
Thailand

Hongyan Li
United Nations Educational, Scientific and Cultural Organization (UNESCO)
China

Wenli Liu
Beijing Normal University
China

Patricia Machawira
United Nations Educational, Scientific and Cultural Organization (UNESCO)
Eastern Southern Africa

Anna-Kay Magnus Watson
Ministry of Education
Jamaica

Vincent Maher
Irish Aid
Ireland

Manak Matiyani
YP Foundation
India

Kristien Michielsen
International Centre for Reproductive Health (ICRH), University of Ghent
Belgium

Beth Miller-Pittman
Education Development Center (EDC)
United States of America

Peter Mladenhov
Y-Peer
Bulgaria

Paul Montgomery
University of Oxford
United Kingdom of Great Britain and Northern Ireland

Venkatraman Mouli-Chandra
World Health Organization (WHO)
Switzerland

Rita Muyambo
World Young Women's Christian Association (World YWCA)
Switzerland

Alan Jarandilla Nuñez
The PACT, Youth Coalition
Bolivia (Plurinational State of)

Hans Olsson
Swedish Association for Sexuality Education (RFSU)
Sweden

Alice Saili
United Nations Educational, Scientific and Cultural Organization (UNESCO)
Zimbabwe

Josephine Sauvarin
United Nations Population Fund (UNFPA)
Asia Pacific

Remmy Shawa
Sonke Gender Justice
Zambia

Saipan Sripongpankul
Ministry of Education
Thailand

Marina Todesco
United Nations Educational, Scientific and Cultural Organization (UNESCO)
France

Aminata Traoré Seck
Ministry of National Education
Senegal

Alice Welbourn
Salamander Trust
United Kingdom of Great Britain and Northern Ireland

Christine Winkelmann
Bundeszentrale für gesundheitliche Aufklärung (BZGA)
Germany

Susan Wood
International Women's Health Coalition (IWHC)
United States of America

Tigran Yepoyan
United Nations Educational, Scientific and Cultural Organization (UNESCO)
Russian Federation

Justine Sass
United Nations Educational, Scientific and Cultural Organization (UNESCO)
France

Jihad Zahir
Y-Peer
Morocco

Ilya Zhukov
United Nations Population Fund (UNFPA)
United States of America

Appendix IV
Criteria for selection of evaluation studies and review methods

Evidence review 2016 (conducted by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention)

Component	Study context
Population	Children and adolescents aged 5-18 (please note that analyses of systematic reviews included young people up to age 24).
Intervention	School-, group- and curriculum-based STI, HIV, sexuality, reproductive health or relationship education interventions (which may be identified using different names, e.g. life-skills or 'family life' programmes, or similar), focused primarily on influencing sexual behaviour, knowledge and attitudes, (as opposed to those mainly aimed at reducing other risk behaviours, such as drug or alcohol use).
Comparison intervention	We will include studies that used the following comparison groups: no intervention; attention-control: interventions that were equal in format and time, but targeted non-sexuality education-related behaviours; comparisons between enhanced and non-enhanced versions of the same programme; usual care or services as usual.
Outcomes	Primary: Behavioural/biological/health outcomes (e.g. incidence of STIs, HIV, pregnancy; age of sexual debut; condom use; other contraceptive use; abstinence; number of sexual partners). Secondary: Knowledge and attitudes about sexual health, sexual risk behaviour and gender; self-confidence, self-awareness, social skills; and other related non-biological outcomes.
Study design	We will include only controlled interventions that evaluated the effects of programmes designed to influence behaviour change or knowledge/attitudes/self-confidence (see outcome measures listed above). These include randomized and quasi-randomized controlled trials. We define quasi-randomized controlled trials as those that approximated randomization by using a method of allocation that was unlikely to lead to consistent bias, such as flipping a coin or alternating participants. Further, all trials must contain a contemporaneous comparison group.

Evidence review 2008 (from the International Techncial Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators. Volume I. The rationale for sexuality education. UNESCO, 2009)

To be included in this review of sex, relationships and HIV/STI education programmes, each study had to meet the following criteria:

1. The evaluated programme had to (a) be an STI, HIV, sex, or relationship education programme that is curriculum-based and group-based (as opposed to an intervention involving only spontaneous discussion, only one-on-one interaction, or only broad school, community, or media awareness activities); and curricula had to encourage more than abstinence as a method of protection against pregnancy and STIs; (b) focus primarily on sexual behaviour (as opposed to covering a variety of risk behaviours such as drug use, alcohol use and violence, in addition to sexual behaviour); and (c) focus on adolescents up to age 24 outside of the US or up to age 18 in the US; (d) be implemented anywhere in the world.

2. The research methods had to (a) include a reasonably strong experimental or quasi-experimental design with well-matched intervention and comparison groups and both pre-test and post-test data collection; (b) have a sample size of at least 100; (c) measure programme impact on one or more of the following sexual behaviours: initiation of sex, frequency of sex, number of sexual partners, use of condoms, use of contraception more generally, composite measures of sexual risk (e.g. frequency of unprotected sex), STI rates,

pregnancy rates, and birth rates; (d) measure impact on those behaviours that can change quickly (i.e. frequency of sex, number of sexual partners, use of condoms, use of contraception, or sexual risk taking) for at least 3 months; or measure impact on those behaviours or outcomes that change less quickly (i.e. initiation of sex, pregnancy rates, or STI rates) for at least 6 months.

3. The study had to be completed or published in 1990 or thereafter. In an effort to be as inclusive as possible, the criteria did not require that studies had been published in peer-reviewed journals.

Review methods:

In order to identify and retrieve as many of the studies throughout the world as possible, several task were completed, several of them on an ongoing basis over two to three years.

1. Reviewed multiple computerized databases for studies meeting the criteria (i.e., PubMed, PsychInfo, Popline, Sociological Abstracts, Psychological Abstracts, Bireme, Dissertation Abstracts, ERIC, CHID, and Biologic Abstracts).

2. Reviewed the results of previous searches completed by Education, Training and Research Associates and identified those studies meeting the criteria specified above.

3. Reviewed the studies already summarized in previous reviews completed by others.

4. Contacted 32 researchers who have conducted research in this field and asked them to review all the studies previously found and to suggest and provide any new studies.

5. Attended professional meetings, scanned abstracts, spoke with authors and obtained studies whenever possible.

6. Scanned each issue of 12 journals in which relevant studies might appear. This comprehensive combination of methods identified 109 studies meeting the criteria above. These studies evaluated 85 programmes (some programmes had multiple articles).

The review team identified the following number of sexuality education programmes demonstrating effects on sexual behaviours:

	Developing countries (N=29)	United States (N=47)	Other developed countries (N=11)	All countries (N=87)	
Initiation of Sex					
Delayed initiation	6	15	2	23	37%
Had no significant impact	16	17	7	40	63%
Hastened initiation	0	0	0	0	0%
Frequency of Sex					
Decreased frequency	4	6	0	10	31%
Had no significant impact	5	15	1	21	66%
Increased frequency	0	0	1	1	3%
Number of Sexual Partners					
Decreased number	5	11	0	16	44%
Had no significant impact	8	12	0	20	56%
Increased number	0	0	0	0	0%
Use of Condoms					
Increased use	7	14	2	23	40%
Had no significant impact	14	17	4	35	60%
Decreased use	0	0	0	0	0%
Use of contraception					
Increased use	1	4	1	6	40%
Had no significant impact	3	4	1	8	53%
Decreased use	0	1	0	1	7%
Sexual Risk-Taking					
Reduced risk	1	15	0	16	53%
Had no significant impact	3	9	1	13	43%
Increased risk	1	0	0	1	3%

Appendix V
Studies referenced as part of the evidence review 2016[5]

(Those marked with * were included in the analysis of systematic reviews and high-quality evaluations.)

*Agbemenu, K. and Schlenk, E. A. 2011. An Integrative Review of Comprehensive Sex Education for Adolescent Girls in Kenya. *Journal of Nursing Scholarship*, 43(1), pp. 54-63. doi:10.1111/j.15475069.2010.01382.x

Akpabio, I. I., Asuzu, M. C., Fajemilehin, B. R. and Ofi, A. B. 2009. Effects of School Health Nursing Education Interventions on HIV/AIDS-Related Attitudes of Students in Akwa Ibom State, Nigeria. *Journal of Adolescent Health*, 44(2), pp. 118-123.

*Amaugo, L. G., Papadopoulos, C., Ochieng, B. M. N. and Ali, N. 2014. The effectiveness of HIV/AIDS school-based sexual health education programmes in Nigeria: a systematic review. *Health Education Research*, 29(4), 633-648. doi:10.1093/her/cyu002

Borawski, E. A., Tufts, K. A., Trapl, E. S., Hayman, L. L., Yoder, L. D. and Lovegreen, L. D. 2015. Effectiveness of health education teachers and school nurses teaching sexually transmitted infections/human immunodeficiency virus prevention knowledge and skills in high school. *The Journal of School Health*, 85(3), pp. 189-196.

Browne, E. 2015. *Comprehensive Sexuality Education (GSDRC Helpdesk Research Report 1226)* Birmingham, UK: GSDRC, University of Birmingham.

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J. and Balain, S. 2007. A conceptual framework for implementation fidelity. *Implementation Science*, 2(1), 40. doi:10.1186/1748-5908-pp. 2-40

Castro, F. G., Barrera, M., Jr. and Martinez, C. R., Jr. 2004. The cultural adaptation of prevention interventions: resolving tensions between fidelity and fit. *Prevention Science*, 5(1), pp. 41-45.

Chandra-Mouli, V., Svanemyr, J., Amin, A., Fogstad, H., Say, L., Girard, F., and Temmerman, M. 2015. Twenty Years After International Conference on Population and Development: Where Are We With Adolescent Sexual and Reproductive Health and Rights? *Journal of Adolescent Health*, 56(1), S1-6. doi:10.1016/j.jadohealth.2014.09.015

Chau, K., Traoré Seck, A., Chandra-Mouli, V., and Svanemyr, J. 2016. Scaling up sexuality education in Senegal: integrating family life education into the national curriculum. *Sex Education*, 16(5), pp. 503-519. doi:10.1080/14681811.2015.1123148

Constantine, N. A., Jerman, P., Berglas, N. F., Angulo-Olaiz, F., Chou, C. P. and Rohrbach, L. A. 2015b. Short-term effects of a rights-based sexuality education curriculum for high-school students: a cluster-randomized trial. *BioMed Central Public Health*, 15,p. 293. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/662/CN-01109662/frame.html doi:10.1186/s12889-015-1625-5

Denno, D. M., Chandra-Mouli, V. and Osman, M. (2012). Reaching Youth With Out-of-Facility HIV and Reproductive Health Services: A Systematic Review. *Journal of Adolescent Health*, 51(2), 106121. doi:10.1016/j.jadohealth.2012.01.004

Denno, D. M., Hoopes, A. J. and Chandra-Mouli, V. 2015. Effective strategies to provide adolescent sexual and reproductive health services and to increase demand and community support. *Journal of Adolescent Health*, 56(1 Suppl), S22-41. doi:10.1016/j.jadohealth.2014.09.012

Durlak, J. 2013. *The importance of quality implementation for research, practice and policy.* Washington, D.C. Office of the Assistant Secretary for Planning and Evaluation (ASPE). Retrieved from https://aspe.hhs.gov/basic-report/importance-quality-implementationresearch-practice-and-policy.

Edwards, S. 2015. *10 things you didn't know about the world's population.* New York, UNFPA. Retrieved from http://www.unfpa.org/news/10-things-you-didn%E2%80%99t-know-aboutworld%E2%80%99s-population

*Farb, A. 2013. The federal evaluation of the enhanced healthteacher teenage pregnancy prevention program. *Journal of Adolescent Health*, 52(2 suppl. 1), S59-s60. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/680/CN-01028680/frame.html doi:10.1016/j.jadohealth.2012.10.139

*Fonner, V. A., Armstrong, K. S., Kennedy, C. E., O'Reilly, K. R., and Sweat, M. D. 2014. School based sex education and HIV prevention in low- and middle-income countries: a systematic review and meta-analysis. *PLoS One*, 9(3), e89692. doi:10.1371/journal.pone.0089692

Fraser, M. 2009. *Intervention Research: Developing Social Programs*. New York, Oxford University Press.

Gardner, F., Montgomery, P. and Knerr, W. 2015. Transporting Evidence-Based Parenting Programs for Child Problem Behavior (Age 3-10) Between Countries: Systematic Review and MetaAnalysis. *Journal of Clinical Child Adolescent Psychology*, 1-14. doi:10.1080/15374416.2015.1015134

Goesling, B., Colman, S., Scott, M., and Cook, E. 2014. Impacts of an Enhanced Family Health and Sexuality Module of the HealthTeacher Middle School Curriculum. Princeton, NJ: *Mathematica Policy Research*. Retrieved from http://www.hhs.gov/ash/oah/oahinitiatives/assets/healthteacher-impact.pdf.

*Goesling, B., Colman, S., Trenholm, C., Terzian, M., and Moore, K. 2014. Programs to reduce teen pregnancy, sexually transmitted infections, and associated sexual risk behaviors: A systematic review. *Journal of Adolescent Health*, 54(5), 499-507.

5 For a full list of the studies referenced as part of the 2008 review, please see the original Guidance (UNESCO, 2009).

Goldacre, B. 2013. *Building evidence into education: UK Department for Education.* Retrieved from http://media.education.gov.uk/assets/files/pdf/b/ben%20goldacre%20paper.pdf

*Guse, K., Levine, D., Martins, S., Lira, A., Gaarde, J., Westmorland, W., and Gilliam, M. (2012). Interventions Using New Digital Media to Improve Adolescent Sexual Health: A Systematic Review. *Journal of Adolescent Health*, 51(6), pp. 535-543. doi: http://dx.doi.org/10.1016/j.jadohealth.2012.03.014

*Haberland, N. A. 2015. The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies. *International Perspectives on Sexual and Reproductive Health*, 41(1), pp. 31-42. doi:10.1363/4103115

Haberland, N. and Rogow, D. 2015. Sexuality Education: Emerging Trends in Evidence and Practice. *Journal of Adolescent Health*, 56(1), S15-21. doi:10.1016/j.jadohealth.2014.08.013

Harden, A., Brunton, G., Fletcher, A., Oakley, A., Burchett, H. and Backhans, M. 2006. *Young people, pregnancy and social exclusion: A systematic synthesis of research evidence to identify effective, appropriate and promising approaches for prevention and support*. London, EPPI-Centre, Social Science Research Unit, Institute of Education, University of London. Retrieved from http://eprints.ioe.ac.uk/5927/1/Harden2006Youngpeople.pdf

Herat, J., Hospital, X., Kalha, U., Alama, A., and Nicollin, L. 2014. *Missing the Target: Using Standardised Assessment Tools to Identify Gaps and Strengths in Sexuality Education Programmes in West and Central Africa*. Paper presented at the 20th International AIDS Conference, Melbourne.

*Hindin, M. J., Kalamar, A. M., Thompson, T.-A. and Upadhyay, U. D. 2016. Interventions to Prevent Unintended and Repeat Pregnancy Among Young People in Low- and Middle-Income Countries: A Systematic Review of the Published and Gray Literature. *Journal of Adolescent Health*, 59, S8-S15. doi:10.1016/j.jadohealth.2016.04.021

Hopewell, S., McDonald, S., Clarke, M. and Egger, M. 2007. Grey literature in meta-analyses of randomized trials of health care interventions. *Cochrane Database Systematic Review*, 2(2).

Howard, M. N., Davis, J. A. and Mitchell, M. E. 2011. Improving Low-Income Teen Health Behaviors with Internet-Linked Clinic Interventions. *Sexuality Research and Social Policy*, 8(1), pp. 50-57. doi:10.1007/s13178-011-0037-2

Hunt, F., Castagnaro, K. and Castrejón, E. 2014. *Evaluation of the Implementation of the Ministerial Declaration: From Commitment to Action – Advances in Latin America and the Caribbean.* New York, International Planned Parenthood Federation (IPPF)/Western Hemisphere Region Inc. Retrieved from https://www.ippfwhr.org/sites/default/files/Ministerial-DeclarationEvaluation-2012.PDF.

Igras, S. M., Macieira, M., Murphy, E. and Lundgren, R. 2014. Investing in very young adolescents' sexual and reproductive health. *Global Public Health*, 9(5), pp. 555-569. doi:10.1080/17441692.2014.908230

International Planned Parenthood Federation (IPPF). 2016. *Sustainable Development Goals and human rights: An introduction for SRHR advocates.* London, IPPF. Retrieved from http://www.ippfen.org/resources/sustainable-development-goals-and-human-rights.

*Kennedy, C. E., Fonner, V. A., O'Reilly, K. R. and Sweat, M. D. 2014. A systematic review of income generation interventions, including microfinance and vocational skills training, for HIV prevention. *AIDS – Psychological and Socio-Medical Aspects of AIDS/HIV*, 26(6), 659673.

Kesterton, A. J. and Cabral de Mello, M. 2010. Generating demand and community support for sexual and reproductive health services for young people: A review of the Literature and Programs. *Reproductive Health*, 7, p. 25. doi:10.1186/1742-4755-7-25

Kirby, D., Laris, B. and Rolleri, L. 2006. *The impact of Sex and HIV Education Programs in Schools and Communities on Sexual Behaviors Among Young Adults*. Research Triangle Park, NC, Family Health International. Retrieved from http://www.sidastudi.org/resources/inmagicimg/dd1054.pdf.

Kivela, J., Haldre, K., Part. K., Ketting. E., Baltussen. R. 2014. Impact and cost-effectiveness analysis of the national school-based sexuality education programme in Estonia. *Sex Education, ol. 14, Iss.1, 2014 http://www.tandfonline.com/action/showCitFormats?doi=10.1080%2F14681811.2013.813386*

Lau, A. S. 2006. Making the Case for Selective and Directed Cultural Adaptations of Evidence-Based Treatments: Examples From Parent Training. *Clinical Psychology: Science and Practice*, 13(4), pp. 295-310. doi:10.1111/j.1468-2850.2006.00042.x

Leijten, P., Melendez-Torres, G. J., Knerr, W. and Gardner, F. 2016. Transported Versus Homegrown Parenting Interventions for Reducing Disruptive Child Behavior: A Multilevel MetaRegression Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 55(7), pp. 610-617. doi:http://dx.doi.org/10.1016/j.jaac.2016.05.003

Liberati, A., Altman, D. G., Tetzlaff, J., Mulrow, C., Gøtzsche, P. C., Ioannidis, J. P. A. Clarke C., Devereaux P.J., Kleijnen J. and Moher, D. 2009. The PRISMA Statement for Reporting Systematic Reviews and Meta-Analyses of Studies That Evaluate Health Care Interventions: Explanation and Elaboration. *PLoS Med*, 6(7), e1000100. doi:10.1371/journal.pmed.1000100

*Lopez, L. M., Bernholc, A., Chen, M. and Tolley, E. 2016. School-based interventions for improving contraceptive use in adolescents. *The Cochrane Library*. doi:10.1002/14651858.CD012249

Lutz, B., and Small, R. 2014. *Cash Transfers and HIV Prevention*. New York, UNDP. Retrieved from http://www.undp.org/content/undp/en/home/librarypage/hiv-aids/discussion-paper--cashtransfers-and-hiv-prevention/.

*Maness, S. B. and Buhi, E. R. 2013. A Systematic Review of Pregnancy Prevention Programs for Minority Youth in the U.S.: A Critical Analysis and Recommendations for Improvement. *Journal of Health Disparities Research and Practice*, 6(2), pp. 91-106.

*Manlove, J., Fish, H. and Moore, K. A. 2015. Programs to improve adolescent sexual and reproductive health in the US: A review of the evidence. *Adolescent Health, Medicine and Therapeutics*, 6,pp. 47-79.

*Mason-Jones, A. J., Crisp, C., Momberg, M., Koech, J., De Koker, P. and Mathews, C. 2012. A systematic review of the role of school-based healthcare in adolescent sexual, reproductive, and mental health. *Systematic Reviews*, 1 (1) (no pagination)(49).

*Mathews, C., Aaro, L. E., Grimsrud, A., Flisher, A. J., Kaaya, S., Onya, H., Klepp, K. I. 2012. Effects of the SATZ teacher-led school HIV prevention programmes on adolescent sexual behavior: Cluster randomised controlled trials in three sub-Saharan African sites. *International Health*, 4(2), 111-122. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/532/CN-00895532/frame.html doi:10.1016/j.inhe.2012.02.001

*Michielsen, K., Chersich, M. F., Luchters, S., De Koker, P., Van Rossem, R. and Temmerman, M. 2010. Effectiveness of HIV prevention for youth in sub-Saharan Africa: Systematic review and meta-analysis of randomized and nonrandomized trials. *AIDS*, 24(8), pp. 1193-1202.

Mkumbo, K. A. K. and Ingham, R. 2010. What Tanzanian parents want (and do not want) covered in school-based sex and relationships education. *Sex Education*, 10(1), pp. 67-78. doi:10.1080/14681810903491396

*Napierala Mavedzenge, S. M., Doyle, A. M., and Ross, D. A. 2011. HIV Prevention in Young People in Sub-Saharan Africa: A Systematic Review. *Journal of Adolescent Health*, 49(6), pp. 568-586. doi:http://dx.doi.org/10.1016/j.jadohealth.2011.02.007

O'Connor, C., Small, S. A. and Cooney, S. M., 4. 2007. *Program fidelity and adaptation: Meeting local needs without compromising program effectiveness*. Madison, WI, University of Wisconsin-Madison/Extension. Retrieved from http://fyi.uwex.edu/whatworkswisconsin/files/2014/04/whatworks_04.pdf

*Oringanje, C., Meremikwu, M. M., Eko, H., Esu, E., Meremikwu, A. and Ehiri, J. E. 2009. Interventions for preventing unintended pregnancies among adolescents. *Cochrane Database of Systematic Reviews*, N.PAG-N.PAG. doi:10.1002/14651858.CD005215.pub2

*Picot, J., Shepherd, J., Kavanagh, J., Cooper, K., Harden, A., Barnett-Page, E., . . . Frampton, G. K. 2012. Behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19 years: a systematic review. *Health Education Research*, 27(3), 495512.

Pound, P., Langford, R. and Campbell, R. 2016. What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *British Medical Journal Open*, 6(9). doi:10.1136/bmjopen-2016-011329

Pulerwitz, J., Gortmaker, S. L. and DeJong, W. 2000. Measuring Sexual Relationship Power in HIV/STD Research. *Sex Roles*, 42(7), pp. 637-660. doi:10.1023/a:1007051506972

Rogow, D., Haberland, N., Del Valle, A., Lee, N., Osakue, G., Sa, Z. and Skaer, M. 2013. Integrating gender and rights into sexuality education: field reports on using It's All One. *Reproductive Health Matters*, 21(41), pp. 154-166. doi:10.1016/s0968-8080(13)41699-3

Rohrbach, L. A., Berglas, N. F., Jerman, P., Angulo-Olaiz, F., Chou, C. P. and Constantine, N. A. 2015. A Rights-Based Sexuality Education Curriculum for Adolescents: 1-Year Outcomes From a Cluster-Randomized Trial. *Journal of Adolescent Health*, 57(4), 399-406. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/910/CN-01131910/frame.html doi:10.1016/j.jadohealth.2015.07.004

Scott, S. and McNeish, D. 2013. *School leadership evidence review: using research evidence to support school improvement*. Bristol, UK, National Centre for Social Research for CUBeC and Dept for Education. Retrieved from http://www.bristol.ac.uk/medialibrary/sites/cubec/migrated/documents/evidencereview3.pdf.

*Shepherd, J., Kavanagh, J., Picot, J., Cooper, K., Harden, A., Barnett-Page, E., . . . Price, A. 2010. The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: A systematic review and economic evaluation. *Health Technology Assessment*, 14(7), 1-230.

Stanton, B., Wang, B., Deveaux, L., Lunn, S., Rolle, G., Li, X., ... Gomez, P. 2015. Assessing the effects of a complementary parent intervention and prior exposure to a preadolescent program of HIV risk reduction for mid-adolescents. *American journal of public health*, 105(3), 575-583. Retrieved from http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/998/CN-01110998/frame.html doi:10.2105/AJPH.2014.302345

Stephenson, J. M., Strange, V., Forrest, S., Oakley, A., Copas, A., Allen, E., ... Johnson, A. M. 2004. Pupil-led sex education in England (RIPPLE study): cluster-randomised intervention trial. *The Lancet*, 364(9431), pp. 338-346. doi:10.1016/S0140-6736(04)16722-6

*Sutton, M. Y., Lasswell, S. M., Lanier, Y. and Miller, K. S. 2014. Impact of Parent-Child Communication Interventions on Sex Behaviors and Cognitive Outcomes for Black/AfricanAmerican and Hispanic/Latino Youth: A Systematic Review, 1988–2012. *Journal of Adolescent Health*, 54(4), 369-384. doi:10.1016/j.jadohealth.2013.11.004

Svanemyr, J., Amin, A., Robles, O. J., and Greene, M. E. 2015. Creating an enabling environment for adolescent sexual and reproductive health: a framework and promising approaches. *Journal of Adolescent Health*, 56(1 Suppl), S7-14. doi:10.1016/j.jadohealth.2014.09.011

*Tolli, M. V. 2012. Effectiveness of peer education interventions for HIV prevention, adolescent pregnancy prevention and sexual health promotion for young people: a systematic review of European studies. *Health Education Research*, 27(5), 904-913. doi:10.1093/her/cys055

UNESCO. 2009. *International Technical Guidance on Sexuality Education: An evidence-informed approach for schools, teachers and health educators.* Paris, UNESCO. Retrieved from http://data.unaids.org/pub/ExternalDocument/2009/20091210_international_guidance_sex uality_education_vol_1_en.pdf.

UNESCO. 2010. *Levers of Success: Case Studies of National Sexuality Education Programmes*. Paris, UNESCO. Retrieved from http://unesdoc.unesco.org/images/0018/001884/188495e.pdf.

UNESCO. 2011. *School-based sexuality education programmes: A Cost and Cost-Effectiveness Analysis in Six Countries.* Paris, UNESCO. Retrieved from http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexualityeducation/costing-study/.

UNESCO. 2015. *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education 2015. A Global Review.* Paris: UNESCO.

UNESCO. 2016. *Education for people and planet: Creating sustainable futures for all (Global Education Monitoring Report 2016*). Paris: UNESCO. Retrieved from http://gem-report2016.unesco.org/en/home/.

UNESCO and UNFPA. 2012. *Sexuality Education: A ten-country review of school curricula in East and Southern Africa.* Paris, UNESCO and UNFPA. Retrieved from http://unesdoc.unesco.org/images/0022/002211/221121E.pdf.

UNESCO and UN Women. 2016. *Global guidance on addressing school-related gender-based violence.* Paris: UNESCO.

UNFPA-ESA. *How effective is comprehensive sexuality education in preventing HIV? Sunninghill.* South Africa, UNFPA Eastern and Southern Africa Regional Office.

UNFPA. 2014. UNFPA *Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender*. New York, UNFPA. Retrieved from http://www.unfpa.org/publications/unfpa-operational-guidance-comprehensive-sexualityeducation

UNFPA. 2016. *Upsurge in sexuality education seen in countries with high HIV rates* [Press release]. Retrieved from http://www.unfpa.org/news/upsurge-sexuality-education-seen-countrieshigh-hiv-rates

UNICEF. 2012. *Global Evaluation of Life Skills Education Programmes. Final Report*. New York, UNICEF.

UNICEF. 2014. *Hidden in Plain Sight: A statistical analysis of violence against children*. New York, UNICEF. Retrieved from https://www.unicef.org/publications/index_74865.html.

USAID. 2012. *Making comprehensive sexuality educaiton available at national scale: A case study about tailoring international guidance for Kenya.* Washington, DC, USAID. Retrieved from https://www.iywg.org/sites/iywg/files/lessons_learned_sexuality_education_kenya.pdf.

Underhill, K., Montgomery, P. and Operario, D. 2007. Sexual abstinence only programmes to prevent HIV infection in high income countries: Systematic review. *British Medical Journal*, Vol. 335, No. 7613, pp. 248-248. http://bmj.com/cgi/content/full/335/7613/248 (Accessed 13 August 2017).

Villa-Torres, L., and Svanemyr, J. 2015. Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs. *Journal of Adolescent Health*, 56(1), S51-S57. doi:10.1016/j.jadohealth.2014.07.022

Visser, M. J. 2005. Life skills training as HIV/AIDS preventive strategy in secondary schools: evaluation of a large-scale implementation process. *SAHARA J: Journal of Social Aspects of HIV/AIDS,* 2(1), 203-216. doi:10.1080/17290376.2005.9724843

Wang, B., Stanton, B., Deveaux, L., Li, X., Koci, V., and Lunn, S. 2014. The impact of parent involvement in an effective adolescent risk reduction intervention on sexual risk communication and adolescent outcomes. *AIDS Education and Prevention*, 26(6), 500-520.

WHO. *Pakistan Country Synthesis Report: Successful Large-Scale Sustained Adolescent Sexual and Reproductive Health Programmes.* Geneva, WHO. (unpublished)

WHO Regional Office for Europe and BZgA. 2010. *Standards for Sexuality Education in Europe. A framework for policy makers, educational and health authorities and specialists.* Cologne, BZgA.

Wight, D. 2011. The effectiveness of school-based sex education: What do rigorous evaluations in Britain tell us? *Education and Health*, 29(4), 72-78.

Wight, D., and Fullerton, D. 2013. A review of interventions with parents to promote the sexual health of their children. *Journal of Adolescent Health*, 52(1), 4-27. doi:10.1016/j.jadohealth.2012.04.014

Appendix VI
People contacted and key informant details for updating key concepts, topics, and learning objectives 2017

A total of 16 interviews were conducted to inform findings and recommendations from the ITGSE update process, with a primary focus on CSE content in order to inform the key concepts, topics, and learning objectives section. Learners and teachers were identified as important key stakeholders, as well as additional expert stakeholders.

Eight primary and secondary school learners ages 10-18 were interviewed from Burkina Faso, Kenya, Ghana, the United States and Guatemala. A total of five teachers, including four primary school teachers and one secondary school teacher were interviewed from Algeria, Burkina Faso, Ghana, and India. In addition, three experts from Bangladesh, Algeria and Malawi, with expertise in curriculum development, gender, life skills, and education, took part.

Key informants were contacted by email or phone either directly or through local organizations and contacts. Once informants had agreed to participate, informed consent protocols were followed. In the case of minors, parental consent forms were also developed and translated for parents of learners under the age of 18. Once informed- and parental-consent had been obtained, arrangements were made for calls. Question guides for each category of respondent were developed consisting of a set of pre-determined questions that were used to guide interviews in English, French and Spanish. All the interviews took place by Skype or telephone, except two where the informants completed the questionnaire in writing, scanned, and returned by email. The Skype and telephone interviews ranged in duration from one to one and half hours. Responses were documented and findings were summarized and incorporated into the desk review that informed updates to the Guidance.

Students, primary and secondary

First name	Age	Country
Soubeiga	10	Burkina Faso
Nacro	10	Burkina Faso
Emmanuel	12	Kenya
Vacaecelia	12	Kenya
Sandra	14	Ghana
Caleb	16	United States
Madelyn	18	United States
Ana	18	Guatemala

Teachers

Name	School level	Country
Angela Bessah Sagoe	Primary school teacher	Ghana
Sam Talato Sandine Nacro	Primary school teacher	Burkina Faso
Sylvie Kansono	Primary school teacher	Burkina Faso
Sakshi Rajeshirke	Primary school teacher	India
Mohamed Beldjenna	Headmaster and secondary school teacher	Algeria

Other stakeholders

Name	Title	Country
Joyce Carol Kasambara	Senior Curriculum Development Specialist	Malawi
Dr. Kamel Bereksi	Président de l'association Santé Sidi El Houari SDH	Algeria
Dr. Rob Ubaidur	Senior Associate and Bangladesh Country Director, Population Council (including oversight of Bangladeshi Association for Life Skills, Income, and Knowledge for Adolescents Project)	Bangladesh

Appendix VII
Bibliography of references and resources used in the updating of the key concepts, topics and learning objectives 2017[6]

References included in desk review

Avni, A. and Chandra-Mouli, V. 2014. Empowering adolescent girls: developing egalitarian gender norms and relations to end violence. *Reproductive Health*, 11: 75. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4216358/

Bonilla, E. 2016. *National Experience of Developing and Delivering Sexuality Education, Mexico*. Presentation at the Consultation on updating International Technical Guidance on Sexuality Education (ITGSE), Paris, October 2016. (Unpublished).

Das M., et al. 2012. *Engaging Coaches and Athletes in Fostering Gender Equity: Findings from the Parivartan Program in Mumbai, India*. New Delhi, ICRW and Futures Without Violence. https://www.icrw.org/wp-content/uploads/2016/10/Parivartan-Engaging-Coaches-and-Athletes-in-Fostering-Gender-Equity.pdf

Dupas, P. 2011. Do teenagers respond to HIV risk information? Evidence from a field experiment in Kenya. *American Economic Journal: Applied Economics*, 3(1), 1-34. http://web.stanford.edu/~pdupas/HIV_teenagers.pdf

Future of Sex Education Initiative. 2012. *National Sexuality Education Standards: Core Content and Skills, K-12.* http://www.futureofsexed.org/nationalstandards.html

Future of Sex Education Initiative. 2012. *National Teacher Preparation Standards for Sexuality Education Standards*. http://www.futureofsexed.org/documents/teacher-standards.pdf

Haberland, N. 2010. *What happens when programs emphasize gender? A review of the evaluation research*. Presentation at Global Technical Consultation on Comprehensive Sexuality Education, 30 November to 2 December, Bogota, Colombia.

Haberland, N. 2015. The case for addressing gender and power in sexuality and HIV education: a comprehensive review of evaluation studies. *International Perspectives Sexual and Reproductive Health*, 41(1), 31-42.

Herat, J., Hospital, X., Kalha, U., Alama, A. and Nicollin, L. 2014. *Missing the Target: Using Standardised Assessment Tools to Identify Gaps and Strengths in Sexuality Education Programmes in West and Central Africa*. Paper for 20th International AIDS Conference, Melbourne, Australia, 20–25 July, 2014.

International Planned Parenthood Federation. 2010. *Framework for Comprehensive Sexuality Education*. London, IPPF. http://www.ippf.org/sites/default/files/ippf_framework_for_comprehensive_sexuality_education.pdf

Kirby, D., Laris, B., and Rolleri, L. 2006. *The impact of Sex and HIV Education Programs in Schools and Communities on Sexual Behaviors Among Young Adults*. New York, Family Health International (FHI). https://www.iywg.org/sites/iywg/files/youth_research_wp_2.pdf

Ministerio de Educación Nacional Republica de Colombia 2016. *Modulo 2, El Proyecto Pedagógico y sus hilos conductores*. http://www.colombiaaprende.edu.co/html/productos/1685/articles-172208_recurso_1.pdf

Ministerio de Educación Nacional, Republica de Colombia, et al. 2016. *Ambientes Escolares Libres de Discriminación*. Bogota, Ministerio de Educación Nacional. https://unicef.org.co/sites/default/files/informes/Ambientes%20escolares%20Libres%20de%20Discriminacion%20May%202016_0.pdf

Ministry of Drinking Water and Sanitation of the Government of India. 2015. *Menstrual Hygiene Management National Guidelines.* http://www.mdws.gov.in/sites/default/files/Menstrual%20Hygiene%20Management%20-%20Guidelines_0.pdf

Montgomery, P. and Knerr, W. 2016. *Updating the United Nations International Technical Guidance on Sexuality Education: Vol. 2. Evidence and recommendations.* Presentation at the Consultation on updating International Technical Guidance on Sexuality Education (ITGSE), Paris, October 2016. (Unpublished).

UNESCO. 2009. *International Technical Guidance on Sexuality Education: An Evidence-informed approach for schools, teachers and health educators*. Paris, UNESCO. http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

UNESCO. 2012. *Good policy and practice in HIV and Health Education. Booklet 7: Gender equality, HIV, and education*. Paris, UNESCO. http://unesdoc.unesco.org/images/0021/002187/218793e.pdf

UNESCO. 2014a. *Good policy and practice in health education. Booklet 9: Puberty education and menstrual hygiene management*. Paris, UNESCO. http://unesdoc.unesco.org/images/0022/002267/226792e.pdf

UNESCO. 2014b. *Comprehensive Sexuality Education: The Challenges and Opportunities of Scaling–Up.* Paris, UNESCO. http://unesdoc.unesco.org/images/0022/002277/227781E.pdf

UNESCO. 2015. *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review.* Paris, UNESCO. http://unesdoc.unesco.org/images/0024/002431/243106e.pdf

UNESCO. 2016. *Out in the Open: Education Sector Responses to Violence based on Sexual Orientation and Gender Identity/Expression.* Paris, UNESCO. http://unesdoc.unesco.org/images/0024/002447/244756e.pdf

6 For a full list of the references used in the development of the original Guidance, please see UNESCO, 2009.

UNESCO. 2016. *Review of the evidence on sexuality education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education*. Prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO.

UNESCO. 2016. *Meeting Notes of the consultation on updating International Technical Guidance on Sexuality Education (ITGSE).* Paris, October 2016. (Unpublished).

UNESCO. 2016. *Survey Findings: Updating the International Technical Guidance on Sexuality Education. Presentation at the Consultation on updating International Technical Guidance on Sexuality Education (ITGSE)*. Paris, October 2016. (Unpublished).

UNESCO-IBE and UNESCO Office Yaoundé. 2014. *Guide pédagogique pour le développement des compétences en éducation à la santé reproductive, au VIH et au SIDA à l'usage des formateurs-trices et des enseignants-es 2014.* Switzerland, UNESCO-IBE. http://unesdoc.unesco.org/images/0022/002294/229421f.pdf

UNESCO and UN Women. 2016. *Global Guidance on Addressing School-Related Gender-Based Violence.* Paris/UNESCO, UNESCO/UN Women. http://unesdoc.unesco.org/images/0024/002466/246651E.pdf

United Nations. 2016. *Ending the torment: tackling bullying from the schoolyard to cyberspace.* New York, Office of the Special Representative of the Secretary-General on Violence against Children. http://srsg.violenceagainstchildren.org/sites/default/files/2016/End%20bullying/bullyingreport.pdf

WHO Regional Office for Europe and BZgA.2010. *Standards for Sexuality Education in Europe. A framework for policy makers, educational and health authorities and specialists*. Cologne, WHO. http://www.oif.ac.at/fileadmin/OEIF/andere_Publikationen/WHO_BZgA_Standards.pdf

Regional and National Frameworks/Guidelines and Curricula

Beaumont and Maguire. 2013. *Policies for Sexuality Education in the European Union. Brussels: Policy Department C - Citizens' Rights and Constitutional Affairs European Parliament.* http://www.europarl.europa.eu/RegData/etudes/note/join/2013/462515/IPOL-FEMM_NT(2013)462515_EN.pdf

The Caribbean Community Secretariat (CARICOM) and UNICEF. 2010. *The Health and Family Life Education Regional Curriculum Framework Ages 5 Years to 12 Years Version 2.1*. Bridgetown, UNICEF. http://www.open.uwi.edu/hflecaribbean/curricula

Colectivo de Autores 2011. *Orientaciones Metodológicas Educación Preescolar, Primaria y Especial.* Ministerio de Educación. http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Havana/pdf/Libro%20Educacion%20de%20la%20sexualidad%201.pdf

Colectivo de Autores 2011. *Orientaciones Metodológicas Educación Secundaria Básica, Preuniversitaria Técnico y Profesional y de Adultos.* http://www.unesco.org/new/fileadmin/MULTIMEDIA/FIELD/Havana/pdf/Libro%20Educacion%20de%20la%20sexualidad%202.pdf

Ministerio de Educación Presidencia de la Nación y Consejo Federal de Educación. 2010. *Lineamientos Curriculares para la Educación Sexual Integral.* http://www.me.gov.ar/me_prog/esi/doc/lineamientos.pdf

Ministerio de Educación, El Salvador. 2014. *Actualización Curricular de la Educación Integral de la Sexualidad en el Sistema Educativo de El Salvador, con Enfoques de Genero y Derechos Humanos (Educación parvularia, primer ciclo, segundo ciclo, tercer ciclo, y educación media*). San Salvador, Ministerio de Educación. https://www.mined.gob.sv/index.php/noticias/item/7212-educacion-integral-de-la-sexualidad

Ministerio de Educación, Perú. 2016. *Currículo Nacional de la Educación Básica*. http://www.minedu.gob.pe/curriculo/pdf/curriculo-nacional-2016-2.pdf

Ministerio de Educación Nacional, Republica de Colombia 2016. *El Proyecto Pedagógico y sus Hilos Conductores.* Bogotá: Ministerio de Educación Nacional. http://www.colombiaaprende.edu.co/html/productos/1685/articles-172208_recurso_1.pdf

Ministerio de Educación Nacional, Republica de Colombia, et al. 2016. *Ambientes Escolares Libres de Discriminación*. Bogota: Ministerio de Educación Nacional. https://unicef.org.co/sites/default/files/informes/Ambientes%20escolares%20Libres%20de%20Discriminacion%20May%202016_0.pdf

Ministerio de Educación, Republica de Panamá 2016. *Guía de Educación de la Sexualidad para Docentes de Educación Primaria (1ºa 6º grado*). http://www.prensa.com/sociedad/Conozca-guias-sexualidad-Meduca_0_4525047519.html

Ministerio de Educación, Republica de Panamá 2016. *Guía de Educación Integral de la Sexualidad para Docentes de Educación Premedia y personal técnico de los Gabinetes Psicopedagógicos*. http://www.prensa.com/sociedad/EIS-PREMEDIA_LPRFIL20160709_0004.pdf

Ministerio de Educación, Republica de Panamá 2016. *Guía de Educación Integral de la Sexualidad para Docentes de Educación Media y Personal Técnico de los Gabinetes Psicopedagógicos (10mo a 12mo grado).* http://www.prensa.com/sociedad/guia-EIS-MEDIA-_meduca-panama_LPRFIL20160709_0003.pdf

Ministry of Drinking Water and Sanitation of the Government of India. 2015. *Menstrual Hygiene Management National Guidelines.* http://www.mdws.gov.in/sites/default/files/Menstrual%20Hygiene%20Management%20-%20Guidelines_0.pdf

Ministry of Education, Republic of Trinidad and Tobago. 2009. *Secondary School Curriculum. Forms 1–3 Health and Family Life Education*. http://www.ibe.unesco.org/curricula/trinidadtobago/tr_ls_lf_2009_eng.pdf

Ministry of Education and Vocational Training of the United Republic of Tanzania. 2010. *National life skills education framework in Tanzania*. http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/Tanzania_National_Life_Skills_Education_Framework_Final_Draft.pdf

Pacific Islands Forum Secretariat. 2009. *Pacific Education Development Framework*. http://www.forumsec.org/resources/uploads/attachments/documents/Pacific%20Education%20Development%20Framework%202009-2015.pdf

UNESCO-IBE and UNESCO Office Yaoundé. 2014. *Guide pédagogique pour le développement des compétences en éducation à la santé reproductive, au VIH et au SIDA à l'usage des formateurs-trices et des enseignants-es 2014*. Switzerland, UNESCO-IBE. http://unesdoc.unesco.org/images/0022/002294/229421f.pdf

WHO Regional Office for Europe and BZgA.2010. *Standards for Sexuality Education in Europe. A framework for policy makers, educational and health authorities and specialists.* Cologne, WHO. http://www.oif.ac.at/fileadmin/OEIF/andere_Publikationen/WHO_BZgA_Standards.pdf

Reviews, consultations, and studies

Agbemenu, K. and Schlenk, E. 2011. An Integrative Review of Comprehensive Sex Education for Adolescent Girls in Kenya. *Journal of Nursing Scholarship*, 43 (1), pp. 54-63. http://onlinelibrary.wiley.com/doi/10.1111/j.1547-5069.2010.01382.x/abstract

Acharya, D.R., Van Teijlingen, E.R., and Simkhada, P. 2009. Opportunities and challenges in school-based sex and sexual health education in Nepal. *Kathmandu University Medical Journal*, 7(28), pp. 445-453. https://www.ncbi.nlm.nih.gov/pubmed/20502093

Alcántara, E. (2012). Alcántara, E. 2012. *Educación sexual en la escuela como base para la equidad social y de género*. UNFPA. http://countryoffice.unfpa.org/dominicanrepublic/drive/EstadodelaeducsexualyVBGenlasescuelas310812.pdf

Amaugo, L.G., Papadopoulos, C., Ochieng, B. and Ali, N. 2014. The effectiveness of HIV/AIDS school-based sexual health education programmes in Nigeria: a systematic review. *Health Education Research*, 29, 4: pp. 633-648. http://www.tandfonline.com/doi/pdf/10.1080/14681811.2015.1123148?needAccess=true

Andrade, H., Brito de Mello, M., Sousa, M., Makuch, M., Bertoni, and N., Faúndes . 2009. Changes in sexual behavior following a sex education program in Brazilian public schools. *Cad. Saúde Pública*, Rio de Janeiro, 25(5), pp:1168-1176. http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/santiago_andrade_2009_changes_in_sexual_behavior_in_brazil_public_schools.pdf

Chau, K., Traoré Seck, A., Chandra-Mouli, V. and Svanemyr, J. 2016. Scaling up sexuality education in Senegal: integrating family life education into the national curriculum. *Sex Education: Sexuality, Society and Learning*, 15 (2), pp. 204-216. http://www.tandfonline.com/doi/full/10.1080/14681811.2015.1123148

Cheney, K. et al. Oosterhoff, P., et al. 2017. Feeling 'Blue': Pornography and Sex Education in Eastern Africa. *IDS Bulletin,* Volume 48, Number 1.UK: Institute of Development Studies.

Chhabra, R., Springer, C., Rapkin, B., and Merchant. (2008). Differences among male/female adolescents participating in a school-based teenage education program (step) focusing on HIV prevention in India. *Ethnicity and Disease*, 18 (Spring 2008), pp. 123-127. http://www.ishib.org/ED/journal/18-2s2/ethn-18-02s2-123.pdf

Clarke, D. 2010. *Sexuality education in Asia: Are we delivering?* An assessment from a rights-based perspective. Bangkok, Plan. http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/bangkok_sexualityeducationasia.pdf

DeMaria, L., Galárraga, O., Campero, L. and Walker, D. 2009. Educación sobre sexualidad y prevención del VIH: Un diagnóstico para América Latina y el Caribe. *Revista Rev Panam Salud Publica*, 26(6), pp. 485–493.

Government of Southern Australia. 2011. *Cyber Safety: Keeping Children Safe in a Connected World.* http://old.decd.sa.gov.au/docs/documents/1/CyberSafetyKeepingChildre.pdf

Haberland, N. and Rogow, D. 2015. Emerging trends in evidence and practice. *Journal of Adolescent Health*, 56, pp. S15eS21. http://www.jahonline.org/article/S1054-139X%2814%2900345-0/pdf

Huaynoca, S., Chandra-Mouli, V., Yaqub Jr, N., and Denno, D. 2014. Scaling up comprehensive sexuality education in Nigeria: from national policy to nationwide application. *Sex Education*, *Sexuality, Society and Learning,* 14(2), pp. 191-209. http://www.tandfonline.com/doi/abs/10.1080/14681811.2013.856292

Ismail, S., Shajahan A., Sathyanarayana Rao, T.S., and Wylie, K. 2015. Adolescent sex education in India: Current perspectives. *Indian Journal of Psychiatry*, 57(4), pp. 333-337. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4711229/

Ministerio de Educación Nacional, Republica de Colombia et al. 2014. *Evaluación del Programa de Educación para la Sexualidad y Construcción de Ciudadanía – PESCC*. https://fys.uniandes.edu.co/site/index.php/component/docman/doc_download/7-informe-evaluacion-programa-de-educacion.../

Munsi, K. and Guha, D. 2014. Status of Life Skill Education in Teacher Education Curriculum of SAARC Countries. A Comparative Evaluation. *Journal of Educaiton and Social Policy*, 1(1), pp. 93-99. http://jespnet.com/journals/Vol_1_No_1_June_2014/13.pdf

Rocha, A.C., Leal, C., and Duarte, C. 2016. School-based sexuality education in Portugal: strengths and weaknesses. *Sex Education: Sexuality, Society and Learning*, 16(2), pp. 172-183. http://dx.doi.org/10.1080/14681811.2015.1087839

Schutte, L. et al. 2014. Long Live Love. The implementation of a school-based sex-education program in the Netherlands. *Health Education Research*. 29 (4), pp. 583-597. https://doi.org/10.1093/her/cyu021

UNAIDS. 2016. *HIV Prevention among adolescent girls and young women.* Geneva: UNAIDS. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_HIV_prevention_among_adolescent_girls_and_young_women.pdf

UNESCO. 2012. *Good policy and practice in HIV and Health Education. Booklet 7: Gender equality, HIV, and education.* Paris, UNESCO. http://unesdoc.unesco.org/images/0021/002187/218793e.pdf

UNESCO. 2012. *Review of Policies and Strategies to Implement and Scale Up/Sexuality Education in Asia and the Pacific*. Bangkok, UNESCO. http://unesdoc.unesco.org/images/0021/002150/215091e.pdf

UNESCO. 2014. *Developing an education sector response to early and unintended pregnancy*. Paris, UNESCO. http://unesdoc.unesco.org/images/0023/002305/230510e.pdf

UNESCO. 2015.*Emerging evidence and lessons and practice in comprehensive sexuality education review*. http://unesdoc.unesco.org/images/0024/002431/243106e.pdf

UNESCO and UN Women. 2016. *Global guidance on addressing School-related gender-based violence*. Paris, UNESCO http://unesdoc.unesco.org/images/0024/002466/246651E.pdf

UNESCO and Radboud University Nijmegen Medical Center. 2011. *Cost and Cost effectiveness analysis. School-based sexuality education programs in six countries*. Paris, UNESCO. http://unesdoc.unesco.org/images/0021/002116/211604e.pdf

UNESCO and UNFPA. 2012. *A ten-country review of school curricula in East and Southern Africa.* Johannesburg, UNESCO. http://unesdoc.unesco.org/images/0022/002211/221121E.pdf

UNESCO, UNFPA, PEPFAR, USAID, Health Communication Capacity Collaborative. 2015. *Comprehensive Sexuality Education in Teacher Training in Eastern and Southern Africa.* Johannesburg, UNESCO. http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/cse_in_teacher_training_in_esa.pdf

UNFPA. 2010. *Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health. A Report on an International Consultation to Review Current Evidence and Experience.* Bogotá, Columbia. http://www.unfpa.org/sites/default/files/resource-pdf/Comprehensive%20Sexuality%20Education%20Advancing%20Human%20Rights%20Gender%20Equality%20and%20Improved%20SRH-1.pdf

UNICEF. 2009. *Strengthening Health and Family Life Education in the Region. The Implementation, Monitoring, and Evaluation of HFLE in Four CARICOM Countries*. Bridgetown, UNICEF. https://www.unicef.org/easterncaribbean/Final_HFLE.pdf

UNICEF. 2012. *Global Evaluation of Life Skills Education Programmes.* New York, UNICEF. https://www.unicef.org/evaluation/files/USA-2012-011-1_GLSEE.pdf

UNICEF. 2013. *Menstrual Hygiene Management in Schools in Two Countries of Francophone West Africa: Burkina Faso and Niger Case Studies.* https://www.unicef.org/wash/schools/files/MHM_study_report_Burkina_Faso_and_Niger_English_Final.pdf

UNICEF. 2013. *The Status of HIV Prevention, Sexuality and Reproductive Health: Fiji, Kiribati, Solomon Islands and Vanuatu.* Suva, UNICEF. https://www.unicef.org/pacificislands/SRH_education_review_report_-_final.pdf

UNICEF and the Ministry of Education. 2011. *An Assessment of the Life-Skills Based Curriculum Project in Lao PDR.* Bangkok, UNICEF and Ministry of Education. https://www.unicef.org/eapro/Assessment_of_the_lifeskills.pdf

UNICEF and Ministry of Education. 2016. *Review of Comprehensive Sexuality Education in Thailand.* Bangkok, UNICEF. http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/comprehensivesexualityeducationthailand_en.pdf

Wood, S. and Rogow, D. 2015. *Can Sexuality Education Advance Gender Equality and Strengthen Education Overall? Learning from Nigeria's Family Life and HIV Education Program*. New York, International Women's Health Coalition. https://iwhc.org/wp-content/uploads/2015/12/Nigeria_FLHE_FINAL-nospreads.pdf

Wood, L. and Rolleri, L. 2014. Designing an effective sexuality education curriculum for schools: lessons gleaned from the Southern African literature. *Sex Education:* Sexuality, Society and Learning, 14 (5), pp. 525-542. http://www.tandfonline.com/doi/abs/10.1080/14681811.2014.918540

Appendix VIII
Proposed indicator for monitoring life skills-based HIV and sexuality education

To assess progress towards implementation of life-skills based HIV and sexuality education in all schools, UNESCO and the UNAIDS Inter-Agency Task Team on HIV and Health Education (IATT), recommend that the education sector measures the indicator **'Percentage of schools that provided life skills-based HIV and sexuality education in the previous academic year'**.

This indicator proposes a set of 'essential' and 'desirable' components of a life skills-based HIV and sexuality education programme that is provided within the formal curriculum (as a standalone examinable subject, or integrated into other curriculum subjects) and/or as part of extra-curricular activities (UNESCO, 2013a). These essential and desirable components are presented below:

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 generic 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 contents	
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 services for counselling, treatment, care and support Other HIV and AIDS-related specific content

Source: UNESCO. 2013a. *Measuring the education sector response to HIV and AIDS: Guidelines for the construction and use of core indicators*. Paris, UNESCO.

United Nations
Educational, Scientific and
Cultural Organization

Education
Sector

Revised edition

International technical guidance on sexuality education

An evidence-informed approach

The UN *International technical guidance on sexuality education* was first published in 2009 as an evidence-informed approach for schools, teachers and health educators. Recognizing the dynamic shifts in the field of sexuality education that have occurred since then, an expanded group of UN co-publishing partners has reviewed and updated the content to respond appropriately to the contemporary needs of young learners, and to provide support for education systems and practitioners seeking to address those needs.

The *International technical guidance on sexuality education (revised edition)* provides sound technical advice on the characteristics of effective comprehensive sexuality education (CSE) programmes; a recommended set of topics and learning objectives that should be covered in comprehensive sexuality education; and, recommendations for planning, delivering and monitoring effective CSE programmes.

This revised edition of the Guidance reaffirms the position of sexuality education within a framework of human rights and gender equality, and promotes structured learning about sex and relationships in a manner that is positive, affirming, and centred on the best interests of the young person. It is based on a review of the latest evidence and lessons-learned from implementing CSE programmes across the globe. The revised Guidance reflects the contribution of sexuality education to the realization of multiple Sustainable Development Goals, notably Goal 3 on good health and well-being for all, Goal 4 on quality education for all, and Goal 5 to achieve gender equality.

9 789231 002595

4 QUALITY EDUCATION

Sustainable Development Goals