GSDRC Applied Knowledge Services
Governance · Social Development · Humanitarian · Conflict

www.gsdrc.org
helpdesk@gsdrc.org

Helpdesk Research Report

Comprehensive sexuality education

Evie Browne

21.05.2015

Question

What evidence is there for comprehensive sexuality education in lower and middle income countries? What measurable outcomes have been associated with delivering CSE? What are the most effective strategies for implementation at scale? (e.g. in relation to gender, age, content, involvement of parents, political buy-in etc.) What challenges are there to applying such approaches in policy and practice?

Contents

1. Overview

Comprehensive sexuality education (CSE) has strong support in the international discourse, and is supported by a relatively robust evidence base. The International Planned Parenthood Federation (IPPF) defines comprehensive sex education as: "Education about all matters relating to sexuality and its expression. Comprehensive sexuality education covers the same topics as sex education but also includes issues such as relationships, attitudes towards sexuality, sexual roles, gender relations and the social pressures to be sexually active, and it provides information about sexual and reproductive health services. It may also include training in communication and decision-making skills."[1]

CSE is rooted in United Nations agreements, particularly the 1994 International Conference on Population and Development's (ICPD) Programme of Action (the Cairo agenda). This calls on governments to provide for the wellbeing of adolescents with education on sexuality, sexual and reproductive health, gender

[1] http://www.ippf.org/resources/media-press/glossary/c

relations, gender equality, and violence against adolescents (Haberland & Rogow, 2015). CSE includes basic health education, but roots its approach in:

- Rights-based approach, including gender and power
- Gender focus
- Participatory learning
- Youth advocacy and civic engagement
- Cultural appropriateness

CSE therefore recognises and promotes human rights, gender equality, and emphasises the need for knowledge, values and skills for sexual health (Haberland & Rogow, 2015). This is an explicitly empowerment-based approach (Haberland & Rogow, 2015).

In general, the evidence suggests that CSE has positive impacts on behaviour change, such as increased condom use, girls' empowerment and delayed sexual debut. This is achieved through increasing knowledge and changing attitudes. There is strong evidence to support the effectiveness of CSE programmes in these areas. However, there is less evidence on whether CSE can change biological indicators, notably incidences of STIs, including HIV, and pregnancies. The literature highlights that this is an area of research which needs more conclusive findings. CSE is mostly implemented through the lens of preventing HIV/AIDS, and is mostly directed at adolescent girls, giving the evidence base a strongly gendered dimension. Most programmes take place in schools. Haberland (2015) provides strong evidence that content on gender and power in intimate relationships is a key characteristic of effective sexuality and HIV education.

The literature generally recommends holistic strategies for delivery which involve parents, teachers and peers as well as young people, and which link to broader factors such as accessible health services and social norms change. Effective programmes seem to use interactive, learner-centred and skills-based teaching approaches.

The key challenge to CSE identified in the literature is that of cultural resistance, which often takes the form of religious or morality-based conservatism. The main argument put forward is that teaching CSE encourages young people to have sex earlier and to engage in sexual activity. There is strong evidence to counteract this point of view.

2. Evidence

Effectiveness

The evidence base on CSE programmes is relatively robust, as they are well-evaluated. There are many randomised controlled trials, longitudinal studies and experimental studies. There are several systematic reviews and meta-analyses, which strengthen the reliability and replicability of findings. There is strong evidence that CSE helps young people delay sexual debut, improve contraceptive use, decrease the number of sexual partners, and decrease unintended pregnancies and sexually transmitted infections (Boonstra, 2011; Braeken & Cardinal, 2008).

A recent comprehensive review (Haberland & Rogow, 2015) provides an in-depth analysis of the literature and evidence on the elements, effectiveness, quality, and country-level coverage of CSE. This concludes:

- Most programmes define success as changed behaviours.
- Many programmes recommend biological indicators as more reliable than self-reported behaviours, but these are more expensive and complex to monitor. Behavioural indicators are limited in evaluating successes.
- Evidence is mixed: some reviews find that programmes are not effective, while others suggest CSE is generally effective.
- Some reviews show that two-thirds of evaluations show reductions in targeted sexual risk behaviours. One-third of programmes do not demonstrate any behaviour change.
- The scale of the reduction is usually quite modest.
- CSE programmes are much less successful at preventing STIs and pregnancy.

Haberland and Rogow (2015) contend that programmes which emphasise gender and power relations were much more likely to show positive effects on STIs and pregnancy than programmes which ignore gender and power (conventional CSE). For example, a programme in Kenya which used critical thinking methods for girls in school to highlight the increased risk of HIV from older men (sugar daddy relationships) managed to reduce pregnancy by 28 per cent. A programme in South Africa reduced herpes simplex by 33 per cent. The authors attribute these significant health outcomes to the programmes' emphasis on empowerment. Haberland (2015) conducted a comprehensive follow-up review of programmes addressing gender or power against programmes not explicitly addressing these. It shows that programmes addressing gender or power were five times more likely to be effective: 80 per cent of these achieved lower rates of STIs or unintended pregnancies. This new evidence suggests that a gender and power approach to CSE is significantly more likely to achieve results than CSE which does not include these factors. However, few programmes as yet implement a gender or power approach.

The most widely-cited guidance document is UNESCO's 2009 International Technical Guidance on Sexuality Education, which is based on a rigorous review of evidence on effectiveness of sexuality education programmes. It considered 87 studies, 29 of which were from developing countries, and consulted with global experts. All were curriculum-based programmes, 70 per cent were implemented in schools and 30 per cent in community or clinic settings. The studies in this review were robust, with experimental or quasi-experimental designs, replicable results, and several shared characteristics producing positive results.

None of the programmes in this comprehensive review had any negative effects on outcomes, but the results were not overwhelmingly positive. Overall, including programmes from the USA and Europe, nearly all programmes increased knowledge and two-thirds changed behaviours, including delayed sexual debut, frequency of sex, number of partners, increased contraceptive use, and reduced risky sex (Boonstra, 2011). In developing countries, most of the programmes demonstrated no significant impact, while a smaller number produced positive results. In total, UNESCO (2009) suggests that the evidence is quite strong for improved condom use, contraceptive use and sexual risk-taking. However, the magnitude of the effect is quite small, lowering risky sexual behaviour by one-third to one-fourth.

A systematic review (Mavedzenge, Doyle & Ross, 2011) states that there is enough positive evidence to recommend the large-scale implementation of adult-led, curriculum based HIV/AIDS programmes. Other types of programmes did not have enough evidence to support rollout, although there are positive indications for: youth-friendly health facilities; community interventions; peer-led school interventions. These require further research to establish effectiveness.

Despite evidence that abstinence-only programmes are ineffective, many countries still rely on these (Haberland & Rogow, 2015). There is a large body of evidence showing that abstinence-only education is not effective in postponing sexual initiation, frequency of sexual activity, number of sexual partners and preventing unintended pregnancy (Braeken & Cardinal, 2008).

Support

Most countries have either national laws and policies, or strategic plans, for implementing some level of sex education for adolescents.

In general, parents in Sub-Saharan Africa express support for teaching sex education in schools (Mkumbo & Ingham, 2010). A survey of 287 parents from one rural and one urban area in Tanzania showed that more than 75 per cent supported the provision of sex and relationships education in schools, however, it is not systematically taught (Mkumbo & Ingham, 2010). These parents also thought sex education should be taught to pupils from the age of 10. Perhaps surprisingly, the issues identified as controversial (condom use, homosexuality and masturbation) were more amenable to rural parents than urban ones. On the whole, all parents supported cognitive (facts and information) and behavioural (skills and relationships) topics, but showed less support for affective topics (attitudes and values).

Along with the holistic approach recommended throughout the literature, there is some evidence that suggests CSE is more effective when the views and attitudes of parents are taken into account (Mkumbo & Ingham, 2010).

In Mexico, the scale-up of an NGO programme relied on societal support, which it gained through advocacy and dissemination of its proven effectiveness (Pick, Givaudan & Reich, 2008). There was broad support from parents, teachers and communities to implement CSE, although some more controversial elements had to be negotiated.

3. Outcomes

There is strong evidence that CSE produces positive behavioural outcomes, generally by increasing knowledge and understanding. However, there is less evidence that CSE has a direct impact on biological outcomes, particularly HIV and STIs (Harrison et al., 2010). Haberland and Rogow (2015) consider behavioural outcomes as a 'lower-level' order of positive change. Changes in health outcomes, such as reduction in STIs and pregnancies, are considered to be a higher bar of effectiveness, and possibly more reliable indicators.

UNESCO's guidance document (2009) identifies evidence that effective programmes can:

- Reduce misinformation;
- increase correct knowledge;
- clarify and strengthen positive values and attitudes;
- increase skills to make informed decisions and act upon them;
- improve perceptions about peer groups and social norms; and
- increase communication with parents or other trusted adults.

Some programmes also have positive impacts on:

- Abstain from or delay the debut of sexual relations;
- reduce the frequency of unprotected sexual activity;
- reduce the number of sexual partners; and
- increase the use of protection against unintended pregnancy and STIs during sexual intercourse.

A recent commentary paper suggests that programmes implemented according to UNESCO's standards increase awareness and change attitudes on gender equality and power structures (Germain, 2015).

Although there is plenty of evidence for changing sexual behaviours, there is no focus as yet on other outcomes, such as gender equality, critical thinking, empowerment, or confidence (Boonstra, 2011). Haberland and Rogow (2015) emphasise that an approach to CSE which emphasises gender, power and rights has a greater likelihood of reducing rates of sexually transmitted infections and unintended pregnancy. There is also some slight evidence to suggest CSE might be able to influence a broader range of social changes, such as early marriage, sexual coercion, sex trafficking, intimate-partner violence (Haberland & Rogow, 2015). As yet there is not enough research conducted on these areas to make a definitive statement.

4. Strategies for implementation at scale

The comprehensive literature review by Haberland and Rogow (2015) states that CSE is far from institutionalised in low- and middle-income countries, even in those with the highest HIV rates and most investment in sexuality education. Many countries have a policy or strategy on CSE, but most are not implementing these effectively at scale. For most countries, CSE is included in either an HIV prevention or life skills curriculum, usually in schools (Haberland & Rogow, 2015).

Haberland's (2015) comprehensive review identifies a few factors across programmes which increase effectiveness. Primarily, effective programmes seem to use interactive, learner-centred and skills-based teaching approaches. This review also found that stating a theory of behaviour change made no significant difference to whether a programme was effective or not, nor did the duration of the intervention. Clinic-based programmes appeared to be more effective than schools-based programmes. Haberland draws on the empirical literature to suggest the following to better include gender and power approaches:

- Explicit attention to gender or power in intimate relationships.
- Fostering critical thinking about how gender norms or power manifest and operate.
- Fostering personal reflection.
- Valuing oneself and recognising one's own power.

Boonstra (2011) identifies four key factors for implementation:

- **Political and social leadership:** champions are needed at every level.
- **Context and resources:** programmes need to be adapted to the specificities of the community's needs and what is possible.
- **Teacher preparation:** teachers need to be trained adequately, or specialists brought in.

- **Meaningful involvement of young people:** young people can play a role in organising and delivering CSE.

These are largely agreed on in the literature.

UNESCO (2009, p.22) provides a list of the characteristics of effective programmes, developed from its comprehensive review of 87 studies:

- Involve experts in research on human sexuality, behaviour change and related pedagogical theory, in the development of curricula.
- Assess the reproductive health needs and behaviours of young people in order to inform the development of the logic model.
- Use a logic model approach that specifies the health goals, the types of behaviour affecting those goals, the risk and protective factors affecting those types of behaviour, and activities to change those risk and protective factors.
- Design activities that are sensitive to community values and consistent with available resources (e.g. staff time, staff skills, facility space and supplies).
- Pilot-test the programme and obtain on-going feedback from the learners about how the programme is meeting their needs.
- Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy.
- Focus narrowly on specific risky sexual and protective behaviours leading directly to these health goals.
- Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them.
- Give clear messages about behaviours to reduce risk of STIs or pregnancy.
- Focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, social norms, attitudes and skills).
- Employ participatory teaching methods that actively involve students and help them internalise and integrate information.
- Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors.
- Provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection.
- Address perceptions of risk (especially susceptibility).
- Address personal values and perceptions of family and peer norms about engaging in sexual activity and/or having multiple partners.
- Address individual attitudes and peer norms toward condoms and contraception.
- Address both skills and self-efficacy to use those skills.
- Cover topics in a logical sequence.

For programmes being implemented in schools, UNESCO (2009) also recommends the following:

- Include at least twelve or more sessions.
- Include sequential sessions over several years.
- Select capable and motivated educators to implement the curriculum.
- Provide quality training to educators.
- Provide on-going management, supervision and oversight.

A follow-up report from UNESCO (2010), which focuses on developing countries (China, Jamaica, Kenya, Mexico, Nigeria and Viet Nam, and regional experience in Latin America and the Caribbean), identifies the following factors as levers of success:

- Commitment to addressing both HIV and AIDS and sexuality education reflected in a favourable policy context;
- tradition of addressing sexuality, however tentatively, within the education system;
- preparatory sensitisation for head teachers, teachers and community members;
- partnerships (and formal mechanisms for these), for example, between education and health ministries and between state and civil society organizations;
- organisations and groups that represent and contribute young peoples' perspectives;
- collaborative processes of curriculum review;
- civil society organisations willing to promote the cause of comprehensive sexuality education, even in the face of considerable opposition;
- identification and active involvement of 'allies' among decision-makers;
- support for in-service training for teachers and for the dissemination of appropriate materials;
- availability of appropriate technical support (such as from UN partners and international nongovernmental bodies), for example in relation to: sensitisation of decision-makers; promoting participatory learning methods by teachers; and engagement in international networks and meetings;
- involvement of young people in sensitising parents, teachers and decision-makers;
- opportunities for decision-makers to participate in school-based sexuality education through observation and dialogue with teachers and students;
- removal of specific barriers to comprehensive sexuality education, such as the withdrawal of homophobic teaching material;
- willingness to resort to international policy and legal bodies.

UNESCO's programme of work in this area also includes a review of strategies for scaling-up (UNESCO, 2014), in the sense of creating national-level, long-term programmes that are not limited by donor funding or reliance on specific organisations. It draws on a review of the published literature, interviews with experts, and case studies from Finland, Kenya, Nigeria, Tanzania, Thailand and Uruguay. The main lessons from this review are:

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

A case study from Mexico provides insights into what works for scaling up an NGO programme into a national government programme (Pick, Givaudan & Reich, 2008). In this case (*Planeando tu Vida*, implemented by IMIFAP) the implementers started with a pilot programme which produced well-documented and disseminated results. Advocacy led to public support for the approach, which was persuasive for the government. The scale-up was facilitated by a public–private partnership between the programme and a government agency that had the administrative capacity to implement the programme on a national scale. The NGO used several strategies to overcome obstacles in the process: demonstrating to government officials the benefits of investing funds in programme development; working one-to-one with individual members of opposing groups; maintaining detailed records of each version of the curriculum and materials in order to establish programme ownership; and creating continuity in implementation (despite political changes) by working with mid-level government officials and promoting common understanding of objectives and activities. The primary strategy was to negotiate and compromise, without losing the fundamental parameters and approach of the programme. This approach of commitment to the programme's fundamental aspects, while showing willingness to compromise on less central aspects, increased the probability of scaling-up.

Political support

Most countries are operating under the framework of the Cairo agreement, and national laws and policies. These help support implementation of CSE programmes. Support from the Ministry of Education plays a critical role in building consensus on the need for CSE (UNESCO, 2009). Political will to implement CSE is more important than having law and policies in place; some countries in Asia-Pacific have implemented CSE effectively without laws, while some with laws have failed to implement effectively (UNESCO, 2012).

However, supportive and inclusive national laws and policies are helpful (UNESCO, 2009). This structural support can help individuals make the case for CSE programmes (UNESCO, 2009). Governments can be held to account to their international agreements; however, UNESCO (2010) emphasises that CSE should not be made a 'political football', as it is young people who will suffer. In China, a programme has used media

advocacy and dissemination strategies to increase public support, which has contributed to the development of sex education into government policy (Liu & Su, 2014).

In Mexico, the NGO IMIFAP used the following strategies for building an effective NGO–government partnership (Pick, Givaudan & Reich, 2008):

- Create political support.
- Develop personal lines of communication and trust.
- Negotiate with opposition groups.
- Assure programme ownership.
- Prepare for changes in government personnel

At the school level, it is crucial to have buy-in and leadership on a CSE programme (UNESCO, 2009). In Vietnam, support from national government was high, but decentralisation meant that the national CSE curriculum was poorly implemented (UNESCO, 2010). Provincial education managers and head teachers needed clear instruction, budget and support, in order to enable their commitment to the curriculum.

At the individual level, cooperation and support from parents can be extremely helpful for implementing a successful CSE programme (UNESCO, 2009). Evidence shows that parental communication with their children can be increased by setting students homework assignments to discuss with their parents (UNESCO, 2009).

Context and resources

UNESCO (2010) identifies free textbooks as a key element of national-level implementation. In Mexico, CSE is included from primary age, and each pupil has this included in their textbook.

A programme in Uganda has recently trialled delivering CSE through a web-based set of learning modules (Ybarra et al., 2014). This programme was rigorously tested with control and intervention groups. The results showed that the content and delivery method were considered feasible and acceptable by the participants, with three in four recommending that ‘other kids like me’ should take the programme. The study provided mobile internet cafes to access the programme. Internet access is still limited in Uganda, but adolescents showed ease and comfort with accessing CSE through a web platform. Web platforms are less expensive that in-person programmes, and may be a cost-effective system for low-resource environments.

Teacher preparation

Many teachers in low- and middle-income countries express a lack of confidence in their abilities to teach sexuality education. Kenya responded to this knowledge gap by implementing a revised syllabus in teacher training colleges for primary schools, which addresses issues of maturation (UNESCO, 2010).

Meaningful involvement of young people

Studies have shown that sexuality education programmes are more effective when young people have a say in developing the curriculum (UNESCO, 2009).

Linking to other programmes

CSE has clear thematic links to programmes on gender equality and to sexual health services. Some programmes are seeking to connect with overlapping efforts such as girls' financial literacy programmes, media campaigns and other gender equality efforts (Haberland & Rogow, 2015).

5. Challenges

Most countries do not yet manage to provide effective CSE in schools (UNESCO, 2009). Barriers to implementation have been identified as insufficient teacher training, lack of resources, parental opposition, and the persistence of cultural taboos around sex (expert comments).

Cultural and religious resistance

Evidence suggests that many people who could deliver CSE are not convinced of the need to provide it, or are reluctant to (UNESCO, 2009). Educators or service providers may believe that sex education leads to early sex, deprives children of innocence, is against their culture or religion, is a role for parents or that parents will object, that they do not possess the skills to teach it effectively, or that it is already covered in biology lessons (UNESCO, 2009). This is a strong theme across the literature, and is identified as the major challenge to implementation.

In China, community resistance to new CSE programmes was strong because parents feared it would teach their children to start having sex at an early age, and that CSE was a Western concept unsuitable for China (UNESCO, 2010). Programmes instead focus on abstinence-only education. Some teachers in China (Rogow et al., 2013) and Thailand (Thaweesit & Boonmongkon, 2009) were found to reinforce gender stereotypes and discrimination in their CSE classes. In Thailand, teachers do not teach CSE despite there being a national policy and curriculum, which the authors attribute to teacher discomfort or resistance (Thaweesit & Boonmongkon, 2009).

In Nigeria, in order to scale up the national CSE programme, the government was forced to modify the curriculum in order to reach consensus (Haberland & Rogow, 2015). Religious and conservative groups achieved a number of changes in the curriculum, including the proviso to adapt the curriculum to suit local cultures (UNESCO, 2010). Cultural resistance and the belief that CSE encourages sexual activity are identified as the most significant challenges in Nigeria (UNESCO, 2010).

There is strong evidence against this claim. Clear and replicable research has shown that CSE does not lead to earlier sexual initiation or an increase in sexual activity (Braeken & Cardinal, 2008).

Teacher skill

Haberland and Rogow (2015) contend that critical thinking skills and democratic values are the most important for building agency, gender equality, and better sexual health. However, most low-income teaching environments tend to be poorly equipped to nurture these skills. Large classes, rote learning, and teachers' level of comfort with talking about sexuality all inhibit effective CSE. A major investment in teaching skills and the culture of learning is required (Haberland & Rogow, 2015).

In Thailand, teachers tend to provide lessons in a directive way, which does not encourage analytical thinking (Thaweesit & Boonmongkon, 2009). CSE requires students to develop the ability to make decisions

and choices for themselves, and directive teaching is not conducive to this (Thaweesit & Boonmongkon, 2009).

In a review of the application of the Population Council's *It's All One* CSE training tool, the authors find that teacher preparedness is the major challenge facing most countries (Rogow et al., 2013). Teachers may not be specifically trained in delivering CSE and may lack knowledge and attitudes to deliver this effectively. The authors recommend that a significant investment is made in teacher training.

In China, UNESCO (2010) found that teachers' demand for training in sexuality education far exceeds the available supply. In Mexico, only half the teachers reported having received CSE training in the past three years (UNESCO, 2010).

A programme in China which targets migrant children identified high teacher turnover as a challenge (Liu & Su, 2014). In response, they started collaborating with university student associations in order to train student teachers in CSE and help develop a longer-term approach to CSE training.

School environment

Many schools in low- and middle-income countries are characterised by coercion of girls, and bullying of boys who do not conform to gender stereotypes (Haberland & Rogow, 2015). In Kenya, many girls drop out of school due to the lack of sanitation facilities, meaning they do not attend the CSE classes, along with their other schooling (UNESCO, 2010).

Marginalisation

Marginalised groups are the hardest to reach. In this context, these include: girls who are out of school, married, living in extreme poverty, or engaged in transactional sex for economic survival; boys in gangs; substance abusers; HIV-positive youth; and those with learning disabilities (Haberland & Rogow, 2015). In particular, most CSE programmes are school-based, and it remains an open question how best to reach those out-of-school. Young people who are repeating years of school may find the curriculum is inappropriate for their actual age (Haberland & Rogow, 2015).

CSE experts recommend that starting young is appropriate, as this can be before gender norms consolidate (Haberland & Rogow, 2015). However, reaching younger children is a challenge (Haberland & Rogow, 2015). There is little literature on primary school CSE efforts. Some community-based programmes show positive evidence from girls' empowerment programmes around the age of eight years.

Lack of planning

The UNESCO review on scaling-up (2014) concludes that a lack of coordination and planning across players is the major challenge for scaling-up. National governments should be in control of the CSE strategy, rather than managing competing interests and interest groups (UNESCO, 2014).

Lack of resources

In Kenya, there are suitable teaching and learning materials, but they are not available in sufficient quantities (UNESCO, 2010). In Vietnam, the textbooks are unclear and inadequate (UNESCO, 2010). In Haiti, there was a lack of facilitators who were able to deliver the CSE training-of-trainers (Rogow et al., 2013).

A study on students with disabilities in KwaZulu-Natal, South Africa, showed that teachers had positive attitudes towards sexuality education and confidence in their abilities, but lacked relevant materials and training (Chirawu et al., 2014). They were more likely to discuss soft topics such as relationships and hygiene than sexual behaviour and practice. Teachers also had an approach to CSE that emphasised risk reduction, and expressed fears about encouraging students to engage in sexual activity. The authors highlight that there are very few services and resources available which specifically discuss the needs of young people with disabilities.

Non-heterosexual relationships

Very few CSE programmes provide information on same-sex relationships. This is identified as a large gap in the literature. In Thailand, a study notes that sex education lessons only identify two genders and one sexual orientation, creating a heteronormativity that excludes many people (Thaweesit & Boonmongkon, 2009).

6. References

Boonstra, H. D. (2011). Advancing sexuality education in developing countries: evidence and implications. *Guttmacher Policy Review,* 14(3), 17-23. http://sparky.guttmacher.org/pubs/gpr/14/3/gpr140317.html

Braeken, D., & Cardinal, M. (2008). Comprehensive sexuality education as a means of promoting sexual health. *International Journal of Sexual Health,* 20(1-2), 50-62. http://dx.doi.org/10.1080/19317610802157051

Braeken, D., Shand, T., & de Silva, U. (2010). *IPPF Framework for Comprehensive Sexuality Education (CSE).* London: International Planned Parenthood Federation. http://www.ippf.org/sites/default/files/ippf_framework_for_comprehensive_sexuality_education.pdf

Chirawu, P., Hanass-Hancock, J., Aderemi, T. J., de Reus, L., & Henken, A. S. (2014). Protect or Enable? Teachers' Beliefs and Practices Regarding Provision of Sexuality Education to Learners with Disability in KwaZulu-Natal, South Africa. *Sexuality and Disability*, 32(3), 259-277. http://dx.doi.org/10.1007/s11195-014-9355-7

Germain, A. (2015). Commentary: Promoting healthy adolescent development through comprehensive sexuality education. *Global public health,* 1-3. http://dx.doi.org/10.1080/17441692.2014.986176

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), 31. http://dx.doi.org/10.1363/4103115

Haberland, N., & Rogow, D. (2015). Sexuality education: Emerging trends in evidence and practice. *Journal of Adolescent Health*, 56(1), S15-S21. http://dx.doi.org/10.1016/j.jadohealth.2014.08.013

Harrison, A., Newell, M. L., Imrie, J., & Hoddinott, G. (2010). HIV prevention for South African youth: which interventions work? A systematic review of current evidence. *BMC Public Health,* 10(1), 102. http://dx.doi.org/10.1186/1471-2458-10-102

Liu, W., & Su, Y. (2014). School-based primary school sexuality education for migrant children in Beijing, China. *Sex Education, 14*(5), 568-581. http://dx.doi.org/10.1080/14681811.2014.934801

Mavedzenge, S. M. N., Doyle, A. M., & Ross, D. A. (2011). HIV prevention in young people in sub-Saharan Africa: a systematic review. *Journal of Adolescent Health,* 49(6), 568-586. http://dx.doi.org/10.1016/j.jadohealth.2011.02.007

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

Pick, S., Givaudan, M., & Reich, M. R. (2008). NGO–government partnerships for scaling up: sexuality education in Mexico. *Development in Practice,* 18(2), 164-175. http://dx.doi.org/10.1080/09614520801897279

Rogow, D., Haberland, N., Del Valle, A., Lee, N., Osakue, G., Sa, Z., & Skaer, M. (2013). Integrating gender and rights into sexuality education: field reports on using It's All One. *Reproductive health matters,* 21(41), 154-166. http://dx.doi.org/10.1016/S0968-8080(13)41699-3

Thaweesit, S., & Boonmongkon, P. (2009). *Sexuality Education and Sexual Harassment: Two Critical Issues on Sexual Reproductive Health and Rights in Thailand.* ARROW. http://www.arrow.org.my/publications/icpd+15narrativereport/icpd15thailandcasestudy.pdf

UNESCO. (2014). *Comprehensive sexuality education: The challenges and opportunities of scaling-u*p. UNESCO. http://unesdoc.unesco.org/images/0022/002277/227781E.pdf

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

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

UNESCO. (2009). *International technical guidance on sexuality education: an evidence-informed approach for schools, teachers and health educators.* UNESCO, UNFPA, UNICEF, WHO, UNAIDS. http://unesdoc.unesco.org/images/0018/001832/183281e.pdf

Ybarra, M. L., Bull, S. S., Prescott, T. L., & Birungi, R. (2014). Acceptability and feasibility of CyberSenga: an Internet-based HIV-prevention program for adolescents in Mbarara, Uganda. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV,* 26(4). http://dx.doi.org/10.1080/09540121.2013.841837

Key websites

- UNESCO: http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/
- UNFPA: http://www.unfpa.org/comprehensive-sexuality-education
- IPPF: http://www.ippf.org/our-work/what-we-do/adolescents/education

Expert contributors

Nicole Haberland, Population Council
Polly Haste, IDS
Joanna Herat, UNESCO
Natalie Hoskin, University of Newcastle
Yue Hu, Beijing Normal University
Susie Jolly, Ford Foundation
Stephen Wood, IDS

Suggested citation

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

About this report

This report is based on three days of desk-based research. It was prepared for the UK Government's Department for International Development, © DFID Crown Copyright 2015. This report is licensed under the Open Government Licence (www.nationalarchives.gov.uk/doc/open-government-licence). The views expressed in this report are those of the author, and do not necessarily reflect the opinions of GSDRC, its partner agencies or DFID.

The GSDRC Research Helpdesk provides rapid syntheses of key literature and of expert thinking in response to specific questions on governance, social development, humanitarian and conflict issues. Its concise reports draw on a selection of the best recent literature available and on input from international experts. Each GSDRC Helpdesk Research Report is peer-reviewed by a member of the GSDRC team. Search over 400 reports at www.gsdrc.org/go/research-helpdesk. Contact: helpdesk@gsdrc.org.