

# Sexuality Education in Europe and Central Asia

State of the Art and Recent Developments



An Overview of 25 Countries



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ASSESSMENT REPORT  
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Commissioned by the Federal Centre for Health Education, BZgA  
and the International Planned Parenthood Federation European Network, IPPF EN

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## Foreword

BZgA

Sexuality education, which ideally should be comprehensive as well as age- and development-appropriate, is a crucial factor in protecting the health and well-being of children and young people as well as supporting them in their sexual and overall development.

The present assessment on the state of sexuality education in Europe and Central Asia was commissioned by the *German Federal Centre for Health Education (BZgA)* in close cooperation with the *International Planned Parenthood Federation – European Network (IPPF EN)*. The intersectoral and interagency cooperation between these organisations ensured that representatives of both governmental and non-governmental organisations (NGOs) were asked to provide information on the current status of sexuality education in their respective country.

Results show that the state of implementation of sexuality education differs widely between and even within countries of the WHO European Region. Despite these differences, the assessment also confirms that sexuality education has become the norm in most countries throughout Europe and Central Asia. Another crucial outcome of the assessment is that in most countries there is a legal basis for sexuality education – one of the prerequisites for ensuring sustainable implementation.

The BZgA has been designated as a WHO Collaborating Centre for Sexual and Reproductive Health since 2003. Germany is among those countries with a very strong commitment at the legal level. The BZgA and the relevant authorities of the 16 federal states are, by law, mandated to organise and conduct sexuality education, in close cooperation with German family counselling institutions and other relevant organisations. Within this process, the BZgA has assumed a recognised role in developing concepts for sexuality education and for ensuring quality assurance. This multisectoral approach ensures high-quality sexuality education for the various age and target groups.

This report aims to contribute to facilitating the implementation of sexuality education on the national level as well as to improving its quality throughout the entire WHO European Region – to increase the health and well-being of children and young people.

**Federal Centre for Health Education (BZgA) , Cologne 2018**

# Foreword

IPPDFEN

IPPF EN is honoured to have contributed to this unique piece of research. It is rewarding to see the final results of such fruitful collaboration with the BZgA. This ground-breaking research fills an important gap and provides a solid base for researchers, programme developers and policymakers. It makes a real contribution to the knowledge about how best to respond to young people's needs and to support their healthy emotional, physical, social and sexual development.

Sexuality education addresses the need to foster emotional-sexual intelligence and the capacity for healthy, intimate bonding and growth. Sexuality education is based on an understanding of the concepts of consent, equity and respect for one's own boundaries and the boundaries of others in intimate relationships and in society in general.

Parents can, and indeed must, play a key role in helping their own children develop healthy relationships. However, they often are not in the position to foster these skills in their children's friends, peers and future partners; only society as a whole can embrace this mission and invest today in the emotional and sexual competence of children and young people in order to increase their well-being and prevent violence, coercion and gender inequity in the future. Social pressure caused by a rigid interpretation of harmful traditional views of femininity and masculinity, particularly with respect to sex and relationships, is the root cause of mental and physical harm and violence among and towards young people. Discrimination and gender inequality cannot be fought without looking at both the causes and the effects. When young people lack these crucial skills, they inevitably face a lack of personal growth and joy as much as a lack of ability to form and foster nurturing and stable relationships with others – relationships that are the bedrock of modern social life and society.

### **IPPF European Network , Brussels 2018**

# Executive Summary

This report presents the results of a new assessment of the status of sexuality education in the European Region of the WHO which includes 53 countries from Western Europe, Eastern Europe and Central Asia\*. It is largely based on answers to a detailed questionnaire sent out to respondents in 25 countries in this region who, it was felt, are well informed about sexuality education in their respective countries. The research project was initiated and implemented by the German Federal Centre for Health Education, BZgA, and the European Network of the International Planned Parenthood Federation, IPPF EN.

## Methodology

An extensive questionnaire was developed on backgrounds and characteristics of extracurricular and school sexuality education as well as closely related topics. Of the 53 countries of the WHO European Region, 25 were selected to take part in the research. The sample constitutes a reasonable representation of the entire region. The respondents selected were representatives of Ministries of Education, Health or Family Affairs or on the staff of national member associations of IPPF EN in the selected countries. All 25 questionnaires sent to IPPF member associations and 15 questionnaires from Ministries were filled out and returned.

## Progress in sexuality education since the year 2000

Remarkable progress has been made in the European Region in developing and integrating sexuality education curricula in formal school settings. In 21 of the 25 countries, there is currently a law, policy or strategy either requiring or supporting it. In all but one country (the UK), most of this development took place during the years 2000–2016. In March 2017, a legal change took place in the UK when it was decided to make sexuality education a statutory subject, which means it must be taught in all schools of the country, now also including the private ones. In three of the remaining four countries some form of sexuality education has nevertheless been implemented or is being prepared. As a result, it can be concluded that school sexuality education is now the rule in the European Region.

The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) was used extensively in making this progress. In eight of the countries, it was used to inform politicians and other decision-makers and to develop or adapt curricula. In four other countries, it was used only for the development or adaptation of a curriculum; and in two more countries it was used to inform politicians and other decision-makers only.

\* The wording 'European Region' is used hereinafter to indicate the WHO European Region, including Central Asia.



## Quality of sexuality education

‘Comprehensive or holistic sexuality education’ means ‘learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. It aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people’s sexual health and well-being’ (WHO/BZgA, 2010).

The sexuality education curricula in 10 countries can be considered ‘comprehensive’, as defined in the 2010 *Standards* (see also Glossary) or in other international guidance documents. Four other countries are approaching the standards of comprehensiveness. Some crucial indicators of comprehensiveness are, first, that the teaching is age- and development-adapted and thus spread out over several years; second, that the aims are related not only to improving knowledge, but also to building competence by clarifying values and norms, including social and gender norms; third, that they also aim to develop protective and caring behavioural skills. Finally, comprehensiveness is indicated by the breadth of topics addressed, which should include issues like gender roles, diversity in sexual orientations

and mutual consent to sexual contact. Seven countries that have some form of sexuality education are still in the process of further developing and integrating it into their school curricula, or to date they have focused solely on biological aspects.

In 11 of the 21 countries where school sexuality-education programmes are in place, it is a mandatory teaching subject, and in six additional countries the subject is partly mandatory, meaning that it is not an obligatory subject in all parts of the country or in every school. In four further countries it is optional, meaning it can be chosen by pupils, or there are alternative options. In most countries, sexuality education starts in primary (or elementary) school and continues in secondary school. In several assessed countries, sexuality education in primary (or elementary) school tends to focus on knowledge of the human body, its functions and changes during puberty as well as on (intimate) human relationships. Topics that are related to sexual intercourse, such as contraception or STI prevention, are usually only dealt with in secondary schools. These topics are almost always taught before young people have their first sexual intercourse, which for 21% of all young people in the region is at age 15. In almost all countries sexuality education is integrated into other, broader teaching subjects; it is rarely a ‘stand-alone’ subject.

## Teacher training

The training of teachers on sexuality education is often a neglected element. Improvements are badly needed in this point. The lack of preparedness of teachers to properly teach and motivate pupils to learn can undermine the results. Teacher training is also essential because these topics can be sensitive and teachers may find them difficult to handle. The focus of good sexuality education lies not just on the transfer of knowledge, but also on discussing social and (harmful) gender norms as well as on developing critical thinking, positive values and behavioural skills. This requires participatory and interactive teaching methods if it is to be effective. Depending on a country's educational model, teachers might only be accustomed to using top-down teaching approaches and are unfamiliar with modern participatory approaches in education. In practice, only in three of the 25 countries had the majority of teachers been sufficiently trained on sexuality education. In the remaining countries, most teachers had not been trained or had participated in only a short (1-day) course. In some countries (notably Finland and Estonia), the teaching of sexuality is integrated into the curricula of all teacher training institutions.

## Opposition to sexuality education

Opposition to sexuality education is still widespread in the region. Only in five countries did respondents feel that there was hardly any opposition. In eight other countries, there was 'some' opposition, and in the remaining 12 countries opposition it was felt to be 'serious'. The main argument against sexuality education is that it precipitates an earlier onset of sexual relations. International research, however, notably that published by UNESCO, clearly indicates that early onset of sexual contacts is not the result of sexuality education. This report provides further evidence for this: The two countries with the lowest percentages of young people that already had started sexual contacts at age 15 (the Netherlands and Switzerland) have had comprehensive sexuality-education programmes for quite a long time.

A second argument against sexuality education has always been, and is once again found in this assessment, that parents, and not the school, should be responsible for teaching their children about this subject. In practice, however, parents and schools should share this responsibility. In those countries where sexuality education is the least developed or absent completely, young people can hardly rely on their parents in this respect, but instead often get unreliable, or even distorted, information from peers and/or the internet.



## Sexuality education and young people's health

In those countries in which sexuality education is well developed, most young people report the school having been an important source of information on sexuality. In countries that have fully developed and comprehensive programmes, use of contraception tends to be high among young people, and teenage birth rates tend to be very low. Conversely, high teenage birth rates are found in all countries where sexuality education is underdeveloped or non-existent.

Special youth-friendly sexual and reproductive health (SRH) services are widely available in 10 of the 25 countries, and in another 10 they exist though their number is insufficient to be easily accessible for all young people in the country needing them. In five countries, youth-friendly SRH services are absent altogether. In more than half of the countries (14), SRH services are free of charge for young people, and in seven further countries such services are subsidised for young people. Contraceptives are usually not available for free; this is the case in only three countries.

# 1 Introduction

# Introduction

This report presents an assessment of the status of sexuality education in the WHO European Region\* which fills a major knowledge gap. It was conducted at the end of 2016 and in early 2017. This region consists of 53 countries, including five countries in Central Asia. Half of those countries (excluding 3 mini-states with less than 100 000 population) are included in this report. Geographically, they are evenly spread across the region, so that the assessment is reasonably representative for the entire region. The information contained in this report was collected by means of a detailed questionnaire sent to respondents in the selected countries and supplemented by data already available in the literature. The next chapter, on methodology, presents essential information on the respondents and on how the information was collected.

\* The wording 'European Region' is used hereinafter to indicate the WHO European Region, including Central Asia.

Heretofore, little was known about the current status of sexuality education in the European Region. There are two previous reports, both having been published in 2006. The first one resulted from the SAFE project<sup>1</sup>, implemented in 26 countries in Western, Northern and Central Europe, but not in Eastern Europe and Central Asia. The second one, produced by the German Federal Centre for Health Education<sup>2</sup>, BZgA, presented data from 14 countries in Europe and two in Central Asia. Six countries in that overview were not included in the SAFE report. Respondents to the BZgA report were either representatives of government agencies or from NGOs, whereas the SAFE project used only respondents from the (NGO) member associations of IPPF European Network (IPPF EN). The current assessment thus fills a gap in the knowledge about sexuality education in the European Region for the following reasons:

1. Many changes have taken place in this area since 2006.
2. Respondents to this assessment were representatives of both government organisations and NGOs in the selected countries.
3. The questionnaire used for this survey was more elaborate than in the previous two surveys.
4. The current assessment is reasonably representative for the entire European region.

For the above-mentioned reasons, the results of the current assessment are hardly comparable with those of the previous two studies. This assessment was a combined initiative of the BZgA and the IPPF EN, and the information from both governmental and NGO sources (mostly IPPF EN member associations) often turned out to complement each other.

By the end of the first decade of this century, international expert organisations had started to become much more active in the field of sexuality education. In 2009, the UNESCO released an overview of studies on the impact of sexuality education and a related volume on topics and learning objectives for sexuality education<sup>3</sup>. In the same year, The Population Council, IPPF and others also published international guidelines on sexuality education<sup>4</sup>. In 2010, the BZgA, a WHO collaborating centre for sexual and reproductive health, released the *Standards for Sexuality Education in Europe* (2010)<sup>5</sup>. And in 2014, the UNFPA released its 'Operational Guidance' on the same theme<sup>6</sup>.

This increased international commitment to sexuality education reflected and in turn stimulated rapid developments in this field, also in the European Region. As a consequence of this and related developments, the two assessments from 2006 are now clearly outdated. In 2015, the UNESCO released a new assessment of the status of sexuality education, covering 48 countries worldwide<sup>7</sup>, albeit with little representation of the European countries. Nine countries in Eastern Europe and Central Asia are included in it, four of which are also represented in the current report (Kazakhstan, Kyrgyzstan, the Russian Federation and Tajikistan). Nevertheless, it is useful to compare this last report because the indicators used in both studies are similar on some points. Finally, in 2016, the European Regional Council of the WHO adopted a new Action Plan for Sexual and Reproductive Health<sup>8</sup> which strongly endorses the need for sexuality education in order to improve SRH.

International organisations have used different definitions of 'sexuality education', although there is much international agreement on preferred approaches and content. The 2015 UNESCO

report (see above) includes an annexe on how it is defined (see Annexe 2 in reference 7). At the country level, various terms are used to refer to sexuality education. Throughout the European Region, the most often used terms are ‘sexuality (or sex) education’ and ‘sex and relationship education’ or ‘relationship and sex education’, ‘life skills education’ as well as ‘moral and sexuality education’. The term ‘family life education’, used in some countries, has become rather rare now, and inasmuch as it is still applied, it tends to include very few elements that are currently perceived as essential for sexuality education. Because school sexuality education in Europe is almost always fully integrated into other curricular subjects (‘stand-alone’ programmes are rare), it is often not even visible as a separate learning theme – and does not have its own label at all. So, though it may look like no sexuality education is taking place, in the vast majority of European countries it is actually being taught in schools.

When, in 2008, the BZgA started developing its *Standards for Sexuality Education in Europe* (2010)<sup>5</sup>, it used the term ‘holistic sexuality education’ for the recommended approaches. In 2016, it was decided to replace this terminology by ‘comprehensive sexuality education’, because by that time all relevant international organisations had started using the latter terminology. The definition of it is included in the Glossary (see above).

However, this report uses only the term ‘sexuality education’, for two reasons: First, the terms ‘holistic’ or ‘comprehensive’ sexuality education are hardly used or not at all at the country level. Second, both terms refer to a type of sexuality education that is characterised by a set of clearly defined quality criteria. In practice, a majority of those quality criteria are met in less than half the European countries, so that most sexuality-

education programmes cannot be labelled ‘holistic’ or ‘comprehensive’. For the same reason, the abbreviation CSE is not used as the overarching term for *all* programmes in the region\*\* and would not apply to the majority of those programmes, as indicated in this report.

\*\* In the UK, it is not possible to use the acronym ‘CSE’, because there it means primarily ‘Child Sexual Exploitation’.

## Structure of the report

The structure of this report is as follows. Chapter 2 briefly describes the methodology used for collecting the information presented. Chapter 3 presents a comparative European overview of the main results of the assessment. The chapters that follow provide the results on a country basis. As far as possible, the same structure of presentation is applied to describe the sexuality education situation in each individual country.

Chapter 4 subsequently deals with

- the most recent laws, policies and strategies related to sexuality education;
- the organisation and implementation of sexuality education;
- sexuality education outside the formal school setting;
- opposition to sexuality education (if applicable);
- good practices and initiatives (if applicable);
- youth-friendly SRH services; and finally
- survey data on the SRH of young people, including sexuality education.

Chapter 5 draws some core conclusions and presents recommendations on how to improve and extend the quality and coverage of sexuality education in the European Region. Finally, the questionnaire used for this assessment, and an overview of BZgA and IPPF EN international publications on sexuality education are presented in the Annexe.

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## References

- 1 The SAFE project (2006). Sexuality education in Europe; a reference guide to policies and practices. Brussels: IPPF European Network.
- 2 BZgA (2006). Country Papers on Youth Sex Education in Europe. Cologne: BZgA.
- 3 UNESCO (2009). International technical guidance on sexuality education. An evidence-informed approach for schools, teachers and health educators. Paris: UNESCO.
- 4 Population Council et al. (2009). It's all one curriculum. New York: Population Council.
- 5 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.
- 6 UNFPA (2014). UNFPA Operational Guidance for Comprehensive Sexuality Education: a focus on human rights and gender. New York: UNFPA.
- 7 UNESCO (2015). Emerging Evidence, Lessons and Practice in Comprehensive, Sexuality Education: a Global Review 2015. Paris: UNESCO. <http://unesdoc.unesco.org/images/0024/002431/243106e.pdf>
- 8 WHO Regional Office for Europe (2016). Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/314532/66wd13e\\_SRHActionPlan\\_160524.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0018/314532/66wd13e_SRHActionPlan_160524.pdf?ua=1)

# 2

Methodology

# Methodology

This report is largely based on the answers given to a questionnaire specially developed and employed for this purpose. Additional information was collected from the literature.

## The questionnaire

The questionnaire (see Annexe) was developed by a core team consisting of researchers and staff of the BZgA and IPPF EN. Two earlier reports on sexuality education in Europe were important sources of inspiration for the development of the questionnaire. In 2006, WHO/Europe and the BZgA published the 'Country Papers on Youth Sex Education in Europe', the first assessment of the status of sexuality education in Europe. It was based mainly on a questionnaire consisting of 19 questions. The respondents were largely representatives of the Ministries of Education of the countries included in the report. The second building block for questionnaire development was that used for the 'SAFE project'. The first SAFE report, which was also an inventory of sexuality education in the European countries, was released in the same year (2006). This project was implemented by the IPPF EN, the World Health Organization (WHO) Europe and Lund University in Sweden. Information was collected through IPPF EN member associations in Europe.

The questionnaire was piloted in two countries – Bosnia-Herzegovina (Sarajevo) and the Netherlands – and adapted on the basis of the results of the pilot project.

The questionnaire was translated into Russian for use in (mainly) Russian-speaking countries (The Russian Federation, Kazakhstan, Kyrgyzstan and Tajikistan).

The questionnaire for the current survey basically covers five fields:

1. laws and policies on sexuality education;
2. implementation of sexuality education;
3. opposition and barriers to sexuality education;
4. youth-friendly SRH services; and
5. research data on adolescent SRH.

## The countries in the sample

The BZgA/WHO 2006 project had been implemented in 16 of the 53 countries in the European Region. The SAFE project in turn covered 26 countries, whereas the present report covers 25 countries of the European Region, all of which were selected with the aim of representing the entire region as well as possible. The main differences with the SAFE sample are as follows: The number of EU countries in the current sample is less than in the SAFE sample. Four Balkan countries were included that were absent in the SAFE sample. And three Central Asian republics plus Georgia were included, all of which were not part of the SAFE sample.

Most importantly, the current sample of respondents included both the Ministries of Education (in a few cases the Ministry of Health or another governmental agency) and the most relevant NGOs, whereas the previous two studies were based almost solely on information from one of these two groups of respondents. In a few cases, the local UNFPA office provided some answers to the questionnaire, requested by our primary respondent.

## Results of the questionnaire study

The questionnaire was sent to two respondents in each country: the IPPF EN member association\*, representing the NGO field, and an informed representative of the Ministry of Education or Health, depending on the responsibilities in the individual countries. All NGOs filled in and returned the questionnaire. Ten countries failed to return a filled-in questionnaire from the Ministry of Education: Bulgaria, Cyprus, Ireland, Kazakhstan, Kyrgyzstan, the fYR of Macedonia, Serbia, Spain, Tajikistan and Ukraine. In two cases (Germany and Switzerland) the questionnaire was

filled in together by the Ministry of Education (Switzerland), the Ministry of Family Affairs (Germany) and an NGO representative. The main reason for their not returning the questionnaire seems to have been that the government was not (yet) or hardly involved in the subject, which made it difficult or impossible to identify the proper respondent in the Ministry who could reasonably fill in the questionnaire. This problem did not occur when identifying informed NGO respondents, because all IPPF EN member associations in all countries where sexuality education was not yet well developed were involved in advocating for sexuality education and were therefore knowledgeable about its current status.

There were few conflicting answers between the two respondents in the countries where both respondents replied. Only in one case did both respondents give diverging answers to questions that concerned facts, though by corresponding with both respondents, these discrepancies could finally be resolved. Where questions asked for opinions, there were more differences between the two respondents. An attempt was made to give credit to both opinions in the country profiles, though in most cases, the answers to both questionnaires complemented each other, in the sense that answers from governmental agencies mostly expressed the official governmental position, whereas an NGO tended to add information from an advocacy point of view.

In all cases, questions in need of clarification were posed to the respondents after receipt of their questionnaires, and such questions were then answered satisfactorily. Once the country profiles had been drafted, these drafts were sent to both respondents (or one, depending on the country) for a final check. In some cases, where deeply

involved in the subject, the local UNFPA office also checked the answers. This turned out to be a very useful procedure, as many false or biased interpretations of the answers in the questionnaires could be corrected in this way.

\* But not in Georgia, because another NGO, Tanadgoma, was much more involved in sexuality education.

# 3

## Regional overview

# Regional overview

## of the current status of sexuality education in 25 countries of the WHO European Region

This overview presents comparative data on the current status of sexuality education in the 25 countries of the European Region included in the current survey. The information is based on answers given on the questionnaire used for the survey. The number of variables for which comparative information is available is limited since most of the data collected can be correctly understood only in the context of the different background situations of the countries concerned, so that not all of them are immediately comparable. Being estimates, some of the data included in this overview should be handled with caution.

The overview is complemented by demographic and behavioural data of young people, that are most relevant in relation to sexuality education. Sources of those data are UN publications on adolescents as well as the latest edition of the survey-based WHO European Region publication on 'Health Behaviour in School-aged Children (HBSC)', which is released every 4 years. Most countries in the European Region participate in this survey. Finally, some core data are included on youth-friendly SRH services, which were collected by means of the same questionnaire used for this study.

## Core data on sexuality education

Table 3.1 presents an overview of the core data on the status of sexuality education in the 25 countries included in this survey. Most of the information collected through the survey questionnaire rarely, or not at all, represents a summary score and not a binary (yes or no) result, first because the variables are essentially qualitative, and second because the results can be interpreted correctly only in the context of answers given to various other questions.

For example, the apparently simple question: ‘Is there a national law on sexuality education?’ may in fact turn out to be a quite complex question, because in some cases such a law exists, whereas in other cases there is only a national policy or a national strategy. Furthermore, in many cases there is no specific law concerning sexuality education, but only one pertaining to healthy lifestyle education or a similar teaching subject, which may include some references to sexuality-education items, and so on. For this reason, the information presented in the table should be interpreted as the ‘best approximation’ of the situation related to a particular variable. The difficulty of categorising countries on various variables is also the reason why only eight sexuality-education-related variables are included in the overview presented.

The overall conclusion is that, in most of the surveyed countries, there is some form of political or legal support for sexuality education in schools. Only in four countries (Georgia, the fYR of Macedonia, the Russian Federation and Serbia) is there no national sexuality education law, policy or strategy. But in three of these countries at least some form of school sexuality education is being implemented or in preparation. In Georgia, the UNFPA and a specialised national NGO (‘Tanadgoma’) are in the process of developing a

national sexuality-education curriculum, in close contact with the Ministry of Education. In Serbia, a successful sexuality-education pilot project took place in one province (Vojvodina), although it is uncertain whether this initiative can be sustained and/or implemented in other provinces. In the Russian Federation, there is also some form of sexuality education, but one that almost exclusively focuses on HIV/STI prevention.

In 18 of the 25 countries there is a clear legal basis for sexuality-education in school. A few other countries (Bosnia and Herzegovina, Cyprus and Latvia) only have a policy or a strategy on sexuality education, though the borderline between a law, on the one hand, and a policy or a strategy, on the other hand, is not always a sharp one. In many cases this legal basis was periodically updated, and as a result in almost all countries the latest adaptation took place in the past decade\*.

The respondents were also asked to what extent the WHO/BZgA *Standards for Sexuality Education in Europe* (2010) was used as an advocacy tool or for the development of a sexuality-education curriculum. The result is a mixed picture: The *Standards* have now been translated into 10 European languages, and they were used over the past 6 years in several countries. In 11 countries,

\* England is the exception, but on March 1, 2017, it was decided that sexuality education would become ‘statutory’ in 2019, i.e. mandatory in all schools.

**Table 3.1: Core data on sexuality education**

Country	Law/ Policy <sup>1</sup> + year	Use of European Standards <sup>2</sup>	Compre- hensiveness <sup>3</sup>	Man- da- tory <sup>4</sup>	Teacher training <sup>5</sup>	Links with YFS <sup>6</sup>	M&E <sup>7</sup>	Resistance in society <sup>8</sup>
Albania	L, 2012	A+C	+++	Y	++	N	Y	Y
Austria	L, 2015	A+C	+++	Y	+	Y	N	S
Belgium (Flanders region)	L, 2010	A+C	+++	Y	+	Y	Y	N
Bosnia and Herzegovina*	S, 2016	A+C	+++	O	+++	Y	Y	Y
Bulgaria	L, 2016	A+C	N.A.	O	+	N	N	Y
Cyprus	P, 2011	C	++	P	?	P	N	Y
Czech Republic	L, 2013	C	++	Y	++	N	P	S
Estonia	L, 2011	A+C	+++	Y	+++	Y	Y	N
Finland	L, 2016	C	+++	Y	+++	Y	Y	N
Georgia	N	N	N.A.	N.A.	N.A.	N.A.	N.A.	Y
Germany	L, 2002	C	+++	Y	+	Y	N	S
Ireland	L, 2010	?	+	P	+	N	Y	S
Kazakhstan	L, 2009	?	+	O	++	?	P	Y
Kyrgyzstan	L, 2015	?	++	O	+	N	?	Y
Latvia	P, 2013	?	+	Y	+	Y	P	Y
Macedonia (fYRoM)	N	A	N.A.	N.A.	N.A.	N.A.	N.A.	S
The Netherlands	L, 2012	A+C	+++	Y	+	P	P	N
The Russian Federation	N	?	+	P	N	N	N.A.	Y
Serbia	N	N	N.A.	N.A.	+	N.A.	N.A.	Y
Spain	L, 2010	N	+	P	N	Y	N	Y
Sweden	L, 2011	N	+++	Y	++	Y	N	N
Switzerland	L, 2008- 2014	A+C	+++	P	++	Y	N	S
Tajikistan	L, 2015	?	+	P	+	?	N	Y
Ukraine	L, 2013	A	+	Y	+++	P	Y	S
United Kingdom (England)	L, 1996	A	+	P	++	P	Y	S

? Insufficient information available; N.A.: Not applicable

\* Canton Sarajevo only

1 Is there a law or policy on sexuality education? + year of approval (latest adaptation); L = Law/decreed/act; P = Policy only; S = Strategy only; N = No

2 Standards for Sexuality Education in Europe (2010) used for: A = Advocacy; C = Curriculum development; N = Hardly or not at all used

3 Summary index law, practice and in country variation, based on six indicators in the survey questionnaire: -- = (almost) not; + = little; ++ = quite; +++ = highly

4 Excluding 'only in biology'. Y = Yes for all pupils; P = Partly (right to opt out, or not in all schools); O = Optional (largely)

5 N = No teacher training; + = only few teachers trained on sexuality education; ++ = several trained; +++ = most or all trained

6 Is there a direct link between sexuality education and Youth-friendly SRH service delivery? Y = Yes; P = Partly; N = No

7 Is there an M&E system in place? Y = Yes; P = Partly; N = No

8 Serious opposition in society against sexuality education? Y = Yes, serious; S = some; N = Hardly or not

the document played a role in the development or adaptation of curricula, and in at least 10 countries it has (also) been used for advocacy purposes. In Georgia, it was also used for curriculum development, but this process is still ongoing and is thus not included in the overview table. It should also be noted that in a number of countries the *Standards* have hardly or not been used at all, although a translation in the national language is available. This is most obviously the case for the Russian-language translation, which played a role only in the FYR of Macedonia and currently also in Georgia, but not yet in the Central Asian countries or the Russian Federation itself. In Ireland, Latvia and Spain the *Standards* have hardly or not been used at all, although English, Latvian and Spanish versions are available.

It is difficult to assess the extent to which the sexuality-education programmes meet the quality criteria outlined in the *Standards*, in other words, to which extent programmes are comprehensive (or holistic). This is mainly because there is quite a wide range of such quality criteria, but also because there is often large variation within one country. For example, a very comprehensive programme was developed in Bosnia and Herzegovina, but to date it has been implemented only in the canton Sarajevo – and it is an optional programme that is not chosen by the majority of pupils. Most of the criteria mentioned in the *Standards* are more or less fulfilled in the Nordic countries, the Netherlands, Belgium, Germany, Austria, Switzerland, and – interestingly – recently also in Albania. Sexuality-education programmes in several other countries are gradually becoming more comprehensive (i.e. those indicated in the table with ‘++’).

Only in 11 out of the 25 countries is sexuality education a mandatory subject in all schools. In the remaining countries, it is either optional or it is mandatory only in some regions or particular

schools. For example, in England and Ireland it is to date mandatory in public (local authority-run) schools but not in private schools (i.e. it is not ‘statutory’).

The training of teachers in delivering a sexuality-education programme is the weak link in many countries. Only in a handful of countries (notably Finland and Estonia) has teacher training in sexuality education been institutionalised to the extent that it has become part of the curriculum of teacher-training colleges and universities. In most other countries teachers are trained in special in-service courses, though usually only a (small) selection of teachers actually participates in such courses. Only in a few countries, like Albania and the canton Sarajevo, have large numbers of teachers been trained in such courses – and in some countries hardly any teachers have been trained.

In slightly less than half of the countries is there a clear link between sexuality education and youth-friendly SRH services. Such links most often mean that information on those services is provided during sexuality-education lessons. It can also mean that the staff of youth-friendly SRH services provides some sexuality-education lessons in schools. Finally, in some countries (for example, Sweden and Estonia), school classes regularly visit youth clinics and get their lessons there, which has the additional advantage that pupils become familiar with a clinic, thereby possibly lowering the threshold of seeking one out when they need services in the future.

Only in about one third of the countries is implementation of sexuality education more or less systematically monitored and sometimes even evaluated. In this context, it should be stressed that sexuality education is almost never an examinable subject, making examinations in

sexuality education during a school year rare. Most often, M&E is rarely given more than marginal attention during the developmental phase of a sexuality-education programme, when there is a need to evaluate the results of a pilot project. In such cases, it serves the clear purpose of determining where a draft programme can be adapted and improved before being finalised.

It is important to note that in half of the countries sexuality education is (still) a sensitive and sometimes heavily disputed issue. Those tend to be countries in which sexuality education is developing (very) slowly or not at all. On the other hand, in only five countries respondents report opposition to sexuality education being hardly or not an issue: Belgium, the Netherlands, Estonia, Finland and Sweden. It is encouraging to see that a sexuality-education programme can be developed and implemented even in countries where there is serious opposition. Albania is an example of this. The most frequently mentioned opposition argument is that sexuality education causes early onset of sexual behaviour, despite all the research indicating that this is not the case. Other arguments often used against sexuality education are that it remains the task of parents and not of the school, and that it will 'spoil the morality' of young people.

## Demographic data

Table 3.2 presents an overview of the core demographic data relevant to sexuality education. Because births in teenage girls are usually unplanned and often unwanted, this is an internationally accepted indicator of the status of adolescent SRH in a country. The teenage abortion rate is not included, because in Europe these data are often (very) incomplete at the country level. For that reason, the WHO and the Guttmacher Institute in New York recently started presenting these data only at regional and sub-regional level, based on a model of estimation<sup>1</sup>.

Table 3.2 shows that there are huge differences in teenage birth rates, ranging from as low as 3 per 1 000 girls aged 15–19 years in Switzerland to as high as 39 in Kyrgyzstan and 38 in Georgia and Tajikistan. The rate is generally low in Northern and Western Europe and high in south-eastern Europe and Central Asia. In the United Kingdom, the rate is still relatively high compared to other Western European countries, although it was reduced by half in the past two decades. Cyprus, having a very low teenage motherhood birth rate, is the exception to the general rule in south-eastern Europe. In almost all countries, the teenage birth rate has shown a declining trend over the past 15 years. Albania is the only exception to this general trend, but it should immediately be added that the latest available data for Georgia also show an upward trend from 40 per 1 000 girls aged 15–19 years in the year 2000 to 51.5 in 2014\*. In general, there has been a rapid

decline (indicated as ‘---’) in the teenage birth rate in countries in which this rate was already fairly low, and a slower or absent decline in countries in which it was and still is high. Finally, the teenage birth rate tends to be very low in those countries where national, comprehensive sexuality-education programmes are in place, and (very) high in countries where sexuality-education programmes are still in an early stage of development.

\* National Centre for Disease Control and Public Health. Health Care; Statistical Yearbook 2014 Georgia. Ministry of Labour, Health and Social Affairs, Tbilisi 2015. Note that this data is more recent than the ‘38’ presented in Table 3.2, but this more recent rate is not comparable to the other rates in Table 3.2.

**Table 3.2: Total population, population aged 15 – 19 years, teenage birth rate and trend in teenage birth rate in 25 European and central Asian countries (latest available comparative data)**

Country	Total population x 1 000	Population 15 – 19 x 1 000	% 15 – 19 in total population	Births per 1 000 women 15 – 19 years	
				Rate	Trend <sup>1</sup>
Albania	2 896	257	8.9 %	22	+
Austria	8 508	470	5.5 %	7	---
Belgium (Flanders region)	11 204	631	5.6 %	8	--
Bosnia and Herzegovina	3 843	279	7.3 %	8	---
Bulgaria	7 246	319	4.4 %	37	-
Cyprus	840	56	6.6 %	5	---
Czech Republic	10 539	463	4.4 %	10	--
Estonia	1 313	60	4.6 %	12	---
Finland	5 451	313	5.6 %	6	--
Georgia	4 490	273	6.1 %	38	--
Germany	80 767	4 054	5.0 %	6	---
Ireland	4 635	283	6.1 %	10	--
Kazakhstan	17 161	1 229	7.2 %	27	-
Kyrgyzstan	5 957	520	8.7 %	39	--
Latvia	1 994	90	4.5 %	13	--
Macedonia (fYRoM)	2 066	137	6.6 %	17	--
The Netherlands	16 829	996	5.9 %	4	---
The Russian Federation	143 202	7 392	5.2 %	23	--
Serbia	7 147	375	5.3 %	19	--
Spain	46 512	2 140	5.1 %	8	-
Sweden	9 645	544	5.6 %	6	-
Switzerland	8 238	439	5.3 %	3	---
Tajikistan	8 074	863	10.7 %	38	-
Ukraine	45 309	2 405	5.3 %	23	--
United Kingdom	64 308	3 864	6.0 %	14	---

Sources: UN data (2016): <http://data.un.org/Data.aspx?d=POP&f=tableCode%3A22> (population by age group).

World Bank (2016): <http://data.worldbank.org/indicator/SP.ADO.TFRT> (teenage birth rate)

1 Period 2000–2015: + = up to 20% increase; – = up to 20% decrease; -- = 20–39% decrease; --- = ≥ 40% decrease

## Sexual behaviour of 15-year-olds in Europe

Only one source includes comparative data on adolescent sexual behaviour for a large number of countries in Europe, namely, the 'Health Behaviour in School-aged Children' (HBSC) study by the European Regional Office of the WHO. Because the same questions are asked in all participating countries, the results are internationally comparable. The study was started in 1993/1994 and is repeated every 4 years. The latest survey was done in 2014/2015, the international report being published in 2016.

The survey includes three questions on sexual behaviour posed to the 15-year-olds:

1. Ever had sexual intercourse?
2. Condom use at last intercourse?
3. Pill use at last intercourse?

Seven of the 25 countries in the survey did not (yet) participate in the latest HBSC survey: Bosnia and Herzegovina, Serbia, Cyprus, Georgia, Kazakhstan, Kyrgyzstan, and Tajikistan. Table 3.3 provides an overview of the sexual-behaviour results of the latest HBSC survey (2016).

The average percentages for boys and girls together were added to this overview. This is because in countries with a dominant 'double standard'\*, there is a strong tendency among boys to over-report and girls to under-report their sexual activities. The combined data therefore better indicate their sexual behaviour.

The results show that about 20 % of the 15-year-old adolescents had had sexual intercourse, ranging from a low of 15 % in the Netherlands and Switzerland to a high of 30 % in Bulgaria. Half or more of the adolescents in all countries reported that they (or their partner) had used a condom at their last intercourse, varying between a low of 50 % in Albania to a high of 81 % in Switzerland. On average, about two-thirds of them did use a condom.

There is no clear sub-regional pattern in the use of condoms (in terms of North-South or East-West differences). The relatively high rates of condom use probably indicate that they are easily available as well as affordable in almost all European countries. Use of oral contraception ('the pill'), on the other hand, shows much more variation across Europe. On average, just over a quarter of the 15-year-old girls (or the boys' partners) had used this method. Pill use at this young age is remarkably high in Germany, Belgium (Flanders) and the Netherlands. It is also above average (in declining order) in Austria, Finland, Switzerland, Sweden, the United Kingdom and the Czech Republic. Pill use in this age group, however, is quite rare in Southern and Eastern European countries as well as in the Baltic States. This could be the result of a lack of reliable knowledge about this method, poor accessibility of services or unaffordable prices for adolescents.

In several countries, the total reported percentages of condom and pill use at last intercourse lie above 100 %, which indicates that many adolescents are using both methods at the same time. This is particularly the case in Germany and the Netherlands (134 %), Austria (125 %), Belgium (124 %) and Switzerland (116 %). These are also the countries with very low teenage birth rates. Countries with high teenage birth rates tend to have a low combined rate of condom and pill use.

\* 'Double standard' means that boys are in general allowed or even encouraged to have sexual relationships, whereas girls are not permitted (or discouraged) of having them.

**Table 3.3: Sexual and contraceptive behaviour of 15-year-old boys and girls in Europe (in %)**

Country	Sexual Experience			Condom Use			Pill use		
	Boys	Girls	B+G*	Boys	Girls	B+G	Boys	Girls	B+G
Albania	39	2	<b>20</b>	63	38	<b>50</b>	19	7	<b>13</b>
Austria	24	20	<b>22</b>	77	74	<b>75</b>	57	43	<b>50</b>
Belgium (Flanders region)	20	18	<b>19</b>	64	52	<b>58</b>	60	68	<b>64</b>
Bulgaria	40	21	<b>30</b>	66	56	<b>61</b>	18	6	<b>12</b>
Czech Republic	23	24	<b>23</b>	74	66	<b>70</b>	29	30	<b>29</b>
Estonia	20	21	<b>20</b>	72	71	<b>71</b>	19	13	<b>16</b>
Finland	25	24	<b>24</b>	73	57	<b>65</b>	30	40	<b>35</b>
Germany	22	19	<b>20</b>	72	67	<b>69</b>	69	62	<b>65</b>
Ireland	21	14	<b>17</b>	64	65	<b>64</b>	23	25	<b>24</b>
Latvia	22	14	<b>18</b>	71	69	<b>70</b>	9	9	<b>9</b>
Macedonia (fYRoM)	36	3	<b>19</b>	64	48	<b>56</b>	29	15	<b>22</b>
The Netherlands	15	16	<b>15</b>	78	65	<b>71</b>	60	66	<b>63</b>
The Russian Federation	26	11	<b>18</b>	67	67	<b>67</b>	-	-	-
Spain	24	19	<b>21</b>	63	77	<b>70</b>	10	14	<b>12</b>
Sweden	24	26	<b>25</b>	61	47	<b>54</b>	32	32	<b>32</b>
Switzerland	17	13	<b>15</b>	82	80	<b>81</b>	35	36	<b>35</b>
Ukraine	24	9	<b>17</b>	80	73	<b>76</b>	17	13	<b>15</b>
United Kingdom	18	23	<b>20</b>	62	57	<b>59</b>	32	33	<b>32</b>
<b>HBSC average</b>	<b>24</b>	<b>17</b>	<b>21</b>	<b>68</b>	<b>62</b>	<b>65</b>	<b>30</b>	<b>27</b>	<b>28</b>

Source: HBSC (2016). Averages for boys + girls were added (rounded off downwards). Reference 2

\* Boys and girls together

## Core data on youth SRH and related services

Apart from sexuality education, the status of youth SRH is particularly affected by the availability and accessibility of SRH services. For this reason, the questionnaire also included several questions on those issues. Only part of this information is included in the comparative overview presented in Table 3.4 since some of the data cannot be quantified or are too qualitative in character. Additional data are included in the country profiles in Chapter 4.

SRH service delivery centres or clinics that mostly or entirely focus on serving young people are available in the vast majority of countries. It is remarkable that there is no relationship between the availability of such services in a country and the status of youth SRH, measured, for instance, by the level of the teenage birth rate. The two countries with the lowest teenage birth rate, Switzerland and the Netherlands, do not have such services, but in some countries with very high teenage birth rates such services are also lacking, such as in Kyrgyzstan (no youth SRH services) and in Georgia (very few youth SRH services). The reason for a low teenage pregnancy rate seems hence to be related rather to the general acceptance of adolescent sexual behaviour in a country, as measured, for example, by minimal or no opposition to sexuality education.

For example, in the Netherlands there was an extensive network of independent youth-friendly SRH service centres available from the 1960s through the early 1990s, but all those centres were then closed as the demand for their services had rapidly declined and because their function had been assumed by family doctors\*. This could happen only because the taboo on adolescent sexuality largely disappeared, and adolescent sexual behaviour became generally accepted. In that changing sociocultural context, adolescents no longer felt the need for a separate

anonymous service only for them. The family doctor was simply closer and easier, and there was nothing to be ashamed of any more. At the other extreme end, Georgia is a clear case of a country where (premarital) adolescent sexual behaviour is strongly prohibited culturally. Between 2006 and 2009, several youth-friendly SRH centres were created, as part of a large youth SRH project. However, it soon turned out that they were hardly being used and were therefore not sustainable. One of the main reasons was that most girls did not dare to use these services, so that the centres were gradually closed after 2009\*\*.

There is a mixed picture in Europe when it comes to whether youth SRH services are free of charge or must be paid for. In half of the countries, (most) SRH services are free of charge for young people, either because SRH services are free of charge for the entire population or because, in other cases, there are special arrangements for young people up to a certain age. In a quarter of the countries surveyed, only some young people have to pay for services, for example, when they are above a certain age, or they have to pay only for some services and not for others. In almost all countries young people have to pay for abortion.

\* Personal information E. Ketting, former board member of 'Rutgers Stichting', the NGO running these youth-friendly clinics

\*\* Result of an evaluation mission by E. Ketting in 2016, on behalf of the UNFPA country office Georgia (internal UNFPA report)

**Table 3.4: Core data on the availability and accessibility of SRH services for youth**

Country	Availability of YFS <sup>1</sup>	Paying SRH services <sup>2</sup>	Paying for contraception <sup>3</sup>	EC availability <sup>4</sup>	Consent age A & C <sup>5</sup>	School as source info <sup>6</sup>
Albania	Few	No	No	Yes	A:16 C:N	?
Austria	Widely	No	Yes	Yes	A:14 C:14	84 %
Belgium (Flanders)	Widely	Partly	Partly	Yes	A:N C:N	86 %
Bosnia and Herzegovina*	Few	Partly	Yes	No	A:18 C:18	?
Bulgaria	Few	Partly	Yes	Yes	A:18 C:14	25 %
Cyprus	No	Yes	Yes	Yes	A:17 C:17	?
Czech Republic	Few	No	Yes	Yes	A:15 C:15	?
Estonia	Widely	Partly	Yes	Yes	A:N C:N	76 %
Finland	Widely	No	Yes	Yes	A:N C:N	?
Georgia	Few	Yes	Yes	Yes	A:18 C:14	10 %
Germany	Widely	No	No	Yes > 13 years	A:14 C:14	83 %
Ireland	Few	Yes	Yes	Yes > 15 years	A:16 C:16	?
Kazakhstan	Widely	No	Yes	No	A:18 C:16	50 %
Kyrgyzstan	No	Yes	Yes	Yes	A:16 C:N	18 %
Latvia	No	Partly	Yes	Yes	A:16 C:16	?
Macedonia (fYRoM)	Few	Partly	Yes	No	A:18 C:N	2 %
The Netherlands	No	Partly	Partly	Yes	A:16 C:N	93 %
The Russian Federation	Widely	No	Partly	Yes > 16 years	A:15 C:N	?
Serbia	Few	No	Yes	Yes	A:16 C:N	?
Spain	Few	No	Partly	Yes > 15 years	A:18 C:16	22 %
Sweden	Widely	No	Yes	Yes	A:N C:N	50 %
Switzerland	No	No	Yes	Yes	A:N C:N	?
Tajikistan	Widely	No	Partly	Yes	A:18 C:15	?
Ukraine	Few	No	Yes	Yes	A:14 C:14	33 %
United Kingdom (England)	Widely	No	No	Yes	A:N C:N	40 %

\* Canton Sarajevo only

1 Are youth-friendly SRH services (widely) available? Few = mostly only some NGO services

2 Do young people have to pay for youth-friendly SRH services?

3 Do young people have to pay for contraception?

4 Is emergency contraception available for young people without a doctor's prescription?

5 What is the age of consent? A = for abortion; C = for contraception. # = age; N = No age of consent

6 For what % of young people is school mentioned as a source of SRH information? (survey data)

There are only three countries in the sample where contraceptives can be obtained for free by young people. In all other countries, they have to pay for it, sometimes at a reduced price if there is a special subsidisation programme for young people. Several respondents from relatively poor countries reported that the price of contraceptives is often a barrier for young people, which confirms the results of a recent IPPF EN study on access to modern contraceptives in Eastern Europe and Central Asia<sup>3</sup>.

In 2015, the European Commission issued an implementing decision that emergency contraception (EC) should be available without a medical prescription, amending the marketing authorisation granted in 2009<sup>4</sup>. Thereafter, EC can now simply be bought, without a medical prescription, in pharmacies or drugstores in (almost all) members of the European Union. Only in a few countries (Germany, Ireland and Spain) is there still a lower age limit for it. Only in three non-EU countries in the sample (Bosnia and Herzegovina, the FYR of Macedonia and Kazakhstan) is EC unavailable without a medical prescription.

In less than half of the countries queried, adolescents may have a problem obtaining medical (prescription) contraceptives (mainly the pill and the IUD) because there is a legal age of consent. Yet this is mostly a problem for the very young as the age of consent is generally 16 years or even younger. Only in Bosnia and Herzegovina and Cyprus does it lie at 18 and 17 years, respectively. In reality, the vast majority of sexually active young adolescents use condoms, if they use any method at all, and condoms are sold throughout all the countries. The age of consent for deciding on abortion without one's parents' permission is a real obstacle for young people. In a quarter of the countries surveyed, all young people can decide on this without permission of a parent. In 10 countries, they can do so from age 16 on (or even younger). Only in 7 countries is the age of

consent set at 17 or 18 years. It should be added that in several countries girls under the legal age of consent can make their own decision if the doctor's judgment is that they are mature enough to do so.

Respondents were asked if survey data are available to indicate the extent to which the school has been an important source of information for young people on sexuality-related issues. In slightly more than half of the countries, such information had recently been collected. The results, presented in the last column of Table 3.4, should be handled with caution, however, as these results are hardly internationally comparable: The age groups in the samples are different or the question has been formulated differently – or for other reasons. For example, in Estonia, where 97% of 16–17-year-olds had received sexuality education in school, the results are very different depending on the age group of the respondents in the survey<sup>5</sup>: 76% of the 16–17-year-old girls had sufficient (or even too much) discussion in school on sexuality-related topics; among the 18–24-year-olds, the rate was 70%; and among the 25–34-year-olds, it was only 48%. The increase with decreasing age probably indicates a gradual improvement and wider coverage of sexuality education in Estonia between 2000 and 2014. In addition to Estonia, school sexuality education is a very important source of information on sexuality-related topics in Belgium, Austria, Germany and the Netherlands. These are also the countries where school sexuality education is well developed. It is an important source for about half of the young people in England, Kazakhstan and Sweden, and it does not seem to be a prominent source in the rest of the countries for which information is available.

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# 4

## Regional overview



# Country Profiles of Sexuality Education

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## ALBANIA

Albania has made remarkable progress in developing and implementing comprehensive sexuality education, thanks mainly to the efforts of the Ministry of Education, the (related) Institute of Educational Development, and the financial and technical support of UNFPA Albania. The IPPF member association 'Albanian Center for Population and Development' (ACPD) and other NGOs played an important role in advocating sexuality education. Since 2015, about 3 000 teachers have been trained to deliver sexuality education. Currently, the programme is implemented only in public schools.





## Laws and policies on school sexuality education

On 8 June 2012, the Ministry of Health adopted a sublegal act entitled 'Approval of the Positioning Paper on Comprehensive Sexuality Education for Young People in Albania'. This positional paper designates the Directorate of Public Health within the Ministry of Education and the Institute of Public Health to inform and guide the health institutions, partners and CSOs to work further on developing sexuality education. The document states the principles of sexuality education; it is comprehensive and based on human rights. It identifies the multisectoral efforts and dimensions of prevention education. The regulation is clearly supportive of comprehensive sexuality education. The sexuality-education programme that was developed, called 'Life Skills and Sexuality Education', consists of a number of modules that have to be included in the curricula of three relevant subjects: biology, health education and physical education. For this programme, three international guidelines or standards were used extensively: The Population Council<sup>1</sup>, UNESCO<sup>2</sup> and the WHO/BZgA *Standards for Sexuality Education in Europe* (2010). These documents were employed for advocacy purposes and for the development of a curriculum. The *Standards* proved useful for the age-appropriate development of curricula for the age groups 10–12, 12–16 and 16–18. In total, the entire programme for all age groups covers 140 teaching hours. Because sexuality education is integrated into the three subjects mentioned, it is mandatory for all pupils. It has been implemented since 2015.

## Organisation and implementation of sexuality education

### Responsibilities

The process of developing sexuality education in schools was started in 2005 by the UNFPA and the Ministry of Education (Institute for Educational Development, IED), the latter being responsible for curriculum development, though other stakeholders have contributed to it as well. The ACPD and other (local) NGOs have been recipients of funds from the UNFPA to do advocacy work on ASRH, including educational work taking place in schools. Teachers and educational professionals were involved in the testing and reviewing of the curriculum. Young people and health professionals were involved via consultations and roundtables.

An expert group established by the Ministry of Education is responsible for developing teaching materials and guidelines, which generally reflect participatory learning approaches. Parents of pupils have not been systematically involved, but awareness is growing that they should be in the near future. NGOs, including ACPD, Stop AIDS, Aksion+ and LGBT organisations, played a complementary role in the process. Some of them deliver specific lessons, such as on the sexual rights of young people, gender equity, youth-friendly services, etc. The NGOs feel that teachers should be encouraged to implement modules in coordination with NGOs that work in the area of SRH and HIV/AIDS, exhibit the work they do, and give concrete information and evidence-based information about the impact of the services they offer.

## Sexuality education in practice

The 'Life Skills and Sexual Education' programme was first piloted for 4 days in two schools in Tirana and two in Vlora, with pupils from grades 4–6 (age 10–12 years), under the authorisation of the Regional Directorates of Education. The results showed positive changes: misinformation among pupils was reduced by 80% and correct knowledge was similarly increased; positive values and attitudes were also strengthened. The findings showed that teachers who had been trained for this pilot were prepared to teach the sexuality-education modules in line with standards. The findings reported that children had understood the concept of comprehensive sexuality education, and they had acquired knowledge and skills related to the topic. After being educated, the

pupils declared being aware that sexuality is not just about sex, but is about communication, power and informed choices. Pupils reported being prepared to take informed decisions about their sexual lives. An evaluation of the training of teachers showed a high level of satisfaction among participating teachers. They expressed their appreciation for the training and stated they were more open when talking to pupils about sexuality; barriers had been reduced.

The curriculum covers a wide range of topics, as is indicated in the table.

To some extent, the information is presented about institutions that provide SRH and HIV/AIDS services, but there is no direct linkage with them.

Main topics dealt with	How extensive?	
	Extensive	Briefly
Biological aspects and body awareness	X	
Pregnancy and birth	X	
Contraception (including at least three effective methods)	X	
HIV/AIDS	X	
STIs	X	
Love, marriage, partnership	X	
Sexual pleasure		X
Sexual orientation	X	
Gender roles	X	
Online media and sexuality	X	
Access to safe abortion in the framework of the national law	X	
Mutual consent to sexual activity	X	
Sexual abuse/violence		X
Domestic violence		X
Human rights and sexuality	X	



## Teacher training

The IED has implemented and monitored an extensive sexuality-education training programme for teachers since 2011. Trainers of teachers have been trained for 110 hours in total, spread over 1 year. There were 3–4 days of formal training of trainers (ToT) courses and after that the trainers gave out homework, provided model teaching lessons and then started to train other teachers (usually 10–30 at a time). The entire process was monitored and evaluated by IED and UNFPA. By the end of 2016, 150 teacher training courses had been implemented nationwide, covering the 13 Regional Education Directorates. The number of teachers reached in this way was about 3 000. Teacher training has as yet been implemented only in public schools, but the organisers are aware that this should be extended to private schools as well. To date, about 20% of all public schools have been reached in this way.

## Sexuality education outside the formal school setting

Sexuality education is also provided in youth centres of the ACPD and a few other organisations. Sessions they provide cover issues like SRH, HIV/AIDS, sexual pleasure, gender and rights, and violence. The ACPD and some other NGOs also provide information through Facebook. Some attention is also paid in the school curricula to vulnerable groups, but there is a need to directly address the needs of such groups. They are generally mentioned only as vulnerable groups, but no specifications are given and no strategies are mentioned for reaching out to them.

The ACPD has carried out roundtables, conferences and awareness-raising campaigns; it has also developed social media messages, and has participated in TV programmes in order to create

a supportive environment for the issue of sexuality among young people.

## Opposition to sexuality education

There is widespread opposition to school sexuality education in the country, stemming from parents and caregivers, community members and teachers as well, who see sexuality education as a factor leading young people into early sex. They also argue that it runs against the Albanian culture, that schools should promote values instead of implementing sexuality education. They feel that sexuality education might be okay for young people but not for children at a young age.

## Recommendations

Improvements that still have to be made are felt to include:

- strengthening the M&E system, for which M&E training is needed;
- reaching out to the underserved young people;
- addressing the topics of gender, pleasure and violence;
- updating specific information on organisations and institutions that provide SRH services;
- co-ordinating education through guest speakers representing various service providers;
- organising information and education sessions with parents and community members.

## Youth-friendly SRH services

Only the ACPD and a few other NGOs provide youth-friendly SRH and HIV/AIDS services.

But general SRH services as well as contraceptive supplies are available free of charge and without age restrictions. Still, studies reveal that young people lack information on this, and the attitudes of the service providers may impede their access to these free services, so they feel it necessary rather to buy contraceptives in pharmacies or supermarkets. Young people have to pay for abortion if they are 18 or older and do not have health insurance. The cost is around USD 45. Abortion carries an age of consent of 16 years. Emergency contraception is available without prescription, and there are no age restrictions for obtaining it. Similarly, condoms are easily available from drugstores and supermarkets.

### Some survey and vital data on young people's SRH

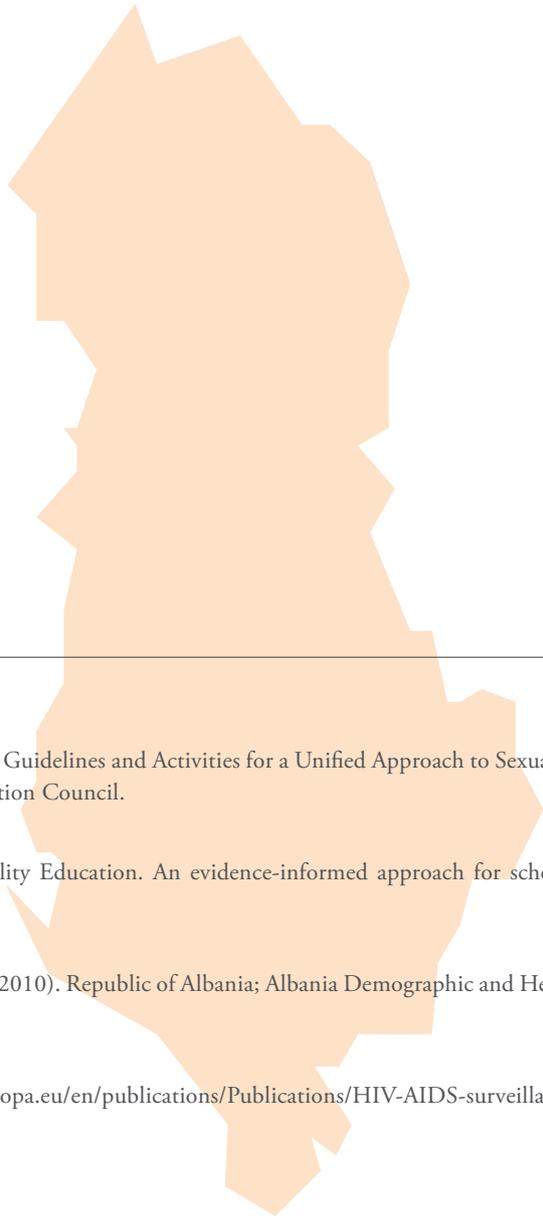
No surveys have been conducted in Albania on adolescent sexuality. The only available source of information is the 2008/2009 Albanian Demographic and Health Survey<sup>3</sup>, which is now 8 years old. Since then, indicators have probably changed. This study has shown that 12.3% of 15–19-year-old and 52.9% of 20–24-year-old women ever had a sexual contact. Less than 1% of the women reported having had their first sexual intercourse before age 15, while more than one-third (36%) had their first sexual intercourse at or before age 20. The median age of first intercourse for women was more than 20 years, which is high compared to other European countries, where it tends to be between 16 and 18 years.

The unmet need for family planning was 16.6% among 15–19-year-old women and 17.7% in the 20–24 age group. The percentages reporting having an STI were 0.6% of men and 1.1% of women. According to the National Institute

of Public Health in Albania (2016), the HIV infection rate was 35.1 per 100 000 population; 8.9% of all HIV infections occurred in the 16–24 age group<sup>4</sup>.



Albania



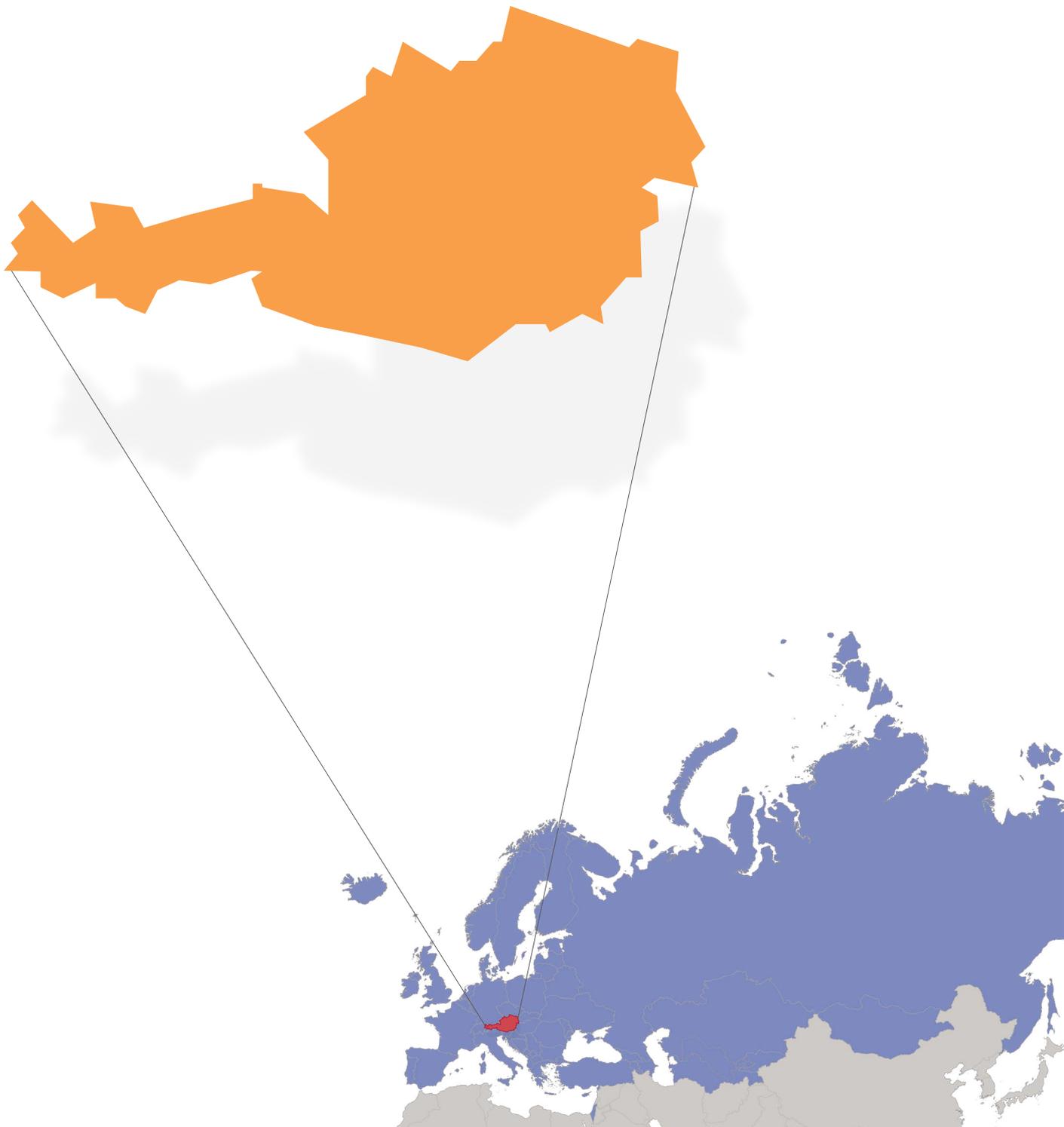
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- 2 UNESCO (2009). *International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators*. Paris: UNESCO.
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- 4 Personal communication. For more details see <http://ecdc.europa.eu/en/publications/Publications/HIV-AIDS-surveillance-Europe-2015.pdf>

## AUSTRIA

In Austria, a law specifically deals with sexuality education and includes the goal of establishing 'adequate competence development in the field of sexuality, and development of positive self-awareness'. The educational programme is mandatory, starting from below age 10 till the end of secondary education. There is little opposition to sexuality education in Austria.





Austria

## Laws and policies on school sexuality education

The legal basis of sexuality education is the 'Grundsatzterlass Sexualpädagogik' (Fundamental Decree on Sexual Education), adopted in 2015. It is a revised version of earlier decrees, the first of which was adopted in 1970. Sexuality education is included in the teaching subject 'Health and Physical Activity'. The Austrian IPPF member association, the 'Österreichische Gesellschaft für Familienplanung' (ÖGF, Austrian Association for Family Planning), which is financed by the Ministry of Families and Youth and by the municipal authorities of women's affairs in Vienna, participated in the revision process, together with some other NGOs. The overall goal of this decree is to ensure 'adequate competence development in the field of sexuality, and development of positive self-awareness'<sup>1</sup>, based on the WHO and BZgA *Standards for Sexuality Education in Europe* (2010) and the 'IPPF Framework for Comprehensive Sexuality Education'.

Sexuality education is integrated into various other school subjects. In primary schools, it is integrated into 'general knowledge' ('Sachkunde'); in secondary schools, it is mainly covered under biology and/or religion. It is meant to be a guiding principle spread out across the different subjects. It is also embedded in health education and is often delivered in the form of projects involving external experts, which is left to the teacher to decide. The programme is mandatory for all pupils. It is spread throughout primary and secondary levels, starting around age 10 and continuing until the end of secondary school, though the duration of the entire programme is not specified. The programme is comprehensive and uses participatory teaching approaches.

In 2016, the Federal Centre for Sexuality Education was founded at the Stefan Zweig University of Education in Salzburg<sup>2</sup>. The aim of the centre is to deliver and support sexuality education in all schools of Austria. From a long-term perspective, the centre will also evaluate sexuality education in Austria.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education is responsible for the curriculum, and input is provided by representatives from other ministries, by educational experts and health professionals, all of whom participate in a curriculum-development working group. Other stakeholders have tried to influence it, among them religious groups and representatives of parents, who are sometimes involved in sexuality-education teaching through so called 'parent-teacher conferences'. Some programmes that take place outside the school and are run by NGOs do obligate parents to become involved. This may take the form of informing parents or the form of workshops with parents. If parents do not agree with (parts of) the curriculum, they can decide that their child will not be allowed to participate in it (opt out).

### Sexuality education in practice

Topics dealt with in the curriculum are listed in the table.

This overview, however, should be understood with caution because the formulation of the curriculum is very general and leaves many options for the teachers when developing lessons.

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth	X		
Contraception (including at least three effective methods)	X		
HIV/AIDS	X		
STIs		X	
Love, marriage, partnership	X		
Sexual pleasure			X
Sexual orientation		X	
Gender roles	X		
Online media and sexuality		X	
Access to safe abortion in the framework of the national law		X	
Mutual consent to sexual activity		X	
Sexual abuse/violence	X		
Domestic violence	X		
Human rights and sexuality	X		

Officially, sexuality education is compulsory in all types of schools, but it still depends on the school and the teacher as to what and how it will be put into practice. There is a link with SRH services through lessons and workshops, which include information on services, but again this depends on teachers.

### Teacher training

Teachers are usually not trained specifically for teaching sexuality education. Only a few of them have been trained in 2–3-day training courses. At the University of Vienna, student teachers can pick an extra optional course on sexuality education. Yet there are no official teaching materials, though NGOs have developed them, and the new Federal Centre for Sexuality Education in Salzburg is now working on one. The ÖGF has developed

teaching materials, including a demonstration kit of contraceptive methods.

There is some opposition to sexuality education in society, mainly from religious and other conservative groups, and by a group of so-called ‘concerned parents’.

There is no system for monitoring implementation of sexuality education.

### Sexuality education outside the formal school setting

Some NGOs provide SRH information to young people, via youth centres where sexuality education is an important issue, and through mass media and social media. This information is concentrated on the prevention of unwanted



Austria

pregnancy and STIs. Examples are:

- First Love, First Love Mobile, First Love Online-Counselling hosted by ÖGF<sup>3</sup>
- ‘Bundesnetzwerk Österreichischer Jugendinfos’ (Federal Network for Youth Information<sup>4</sup>);
- ‘Institut für Sexualpädagogik Wien’ (Institute for Sexual Education Vienna<sup>5</sup>);
- ‘Verein Selbstbewusst Salzburg’ (Society for Self-Confidence<sup>6</sup>);
- ‘Liebenslust, Zentrum für sexuelle Bildung’ (Lust for Love, Centre for Sexual Education<sup>7</sup>);
- ‘Rat auf Draht’ (Online Counselling<sup>8</sup>);
- ‘Kampagne RDN WR KLRSEX der Bundesjugendvertretung’ (Campaign RDN WR KLRSEX of the Federal Youth Representation<sup>9</sup>); and
- ‘queerconnection’: gives workshops in schools<sup>10</sup>.

There are also a variety of programmes for reaching various vulnerable and high-risk groups, all of which are paid for by the government. Examples include:

- ‘Aids Hilfe’ (AIDS Support) has limited and selective services for these groups. The names, aims and content varies from region to region.
- ‘Courage’ is the most important partner as far as young LGBTI people are concerned. They have helpdesks in four different states (including Vienna).

- In Vienna, ‘HOSI’ is an important partner for reaching out to young homo- and bisexual people.
- Young sex-workers in Vienna are best reached by the ‘Zentrum für sexuelle Gesundheit’ (Centre for Sexual Health), ‘LEFÖ and SOPHIE!’
- FEM/MEN and ÖGF offer workshops for undocumented migrants in Vienna, unaccompanied underage refugees and other vulnerable groups, always facilitated by one male and one female expert, and implemented in an age-appropriate manner.
- Use of a contraceptive suitcase (first version created in 1987 by ÖGF) including all contraceptives. Many information materials were developed and are being delivered by the ÖGF.
- In 2017, the ÖGF plans to publish a ‘Method Manual of Sexuality Education’ for sexuality educators.

One initiative that should also be mentioned is ‘SexTalks’<sup>11</sup>, which conducts workshops with young people where they learn how to differentiate between reliable and unreliable information on websites concerning love and sexuality. It is partly funded by the Austrian Ministry for Families and Youth.

### Recommendations

The ÖGF and the Ministry for Families and Youth make the following recommendations:

- The Fundamental Decree on Sexuality Education is a good start, but it still needs concrete formulations concerning the knowledge pupils

should have upon leaving school as well as implementation instructions.

- Sexuality education should be made part of the curricula of all teachers, including kindergarten

teachers, during their education at university, as well as all people working in the health sector on SRHR-related issues. In-service training, and education and training on basic pedagogics, are also needed.

- Monitoring and evaluation of sexuality education is necessary in order to grasp remaining specific needs.

### Youth-friendly SRH services

There are numerous youth-friendly SRH services, particularly in the capital city of Vienna. They are integrated in other health services, such as hospitals run by the individual federal states. Important ones are:

- youth information centres<sup>12</sup>;
- ‘first love’ centres hosted by the ÖGF<sup>13</sup>;
- family counselling centres that are also relevant to young people<sup>14</sup>;
- the website Youth Portal<sup>15</sup>.

The ÖGF is the only provider of anonymous youth-friendly SRH services that are free of charge – and that only in Vienna. Except for abortion, all SRH services are available free of charge for young people, though contraceptives have to be paid for. This is a barrier for at least some young people, according to the ÖGF, which provides some contraceptives free to people with very low or no income. Emergency contraception

is available from pharmacies without prescription or restrictions, but the price is relatively high (€13–32). Condoms are for sale in supermarkets and other outlets. The legal age of consent for obtaining contraception and for abortion is 14. In exceptional cases, a doctor can decide that a person younger than 14 is ‘able to understand and to make a decision’ (‘Einsichts- und Urteilsfähigkeit’) and then prescribe contraception or perform an abortion.

### Some survey and vital data on young people’s SRH

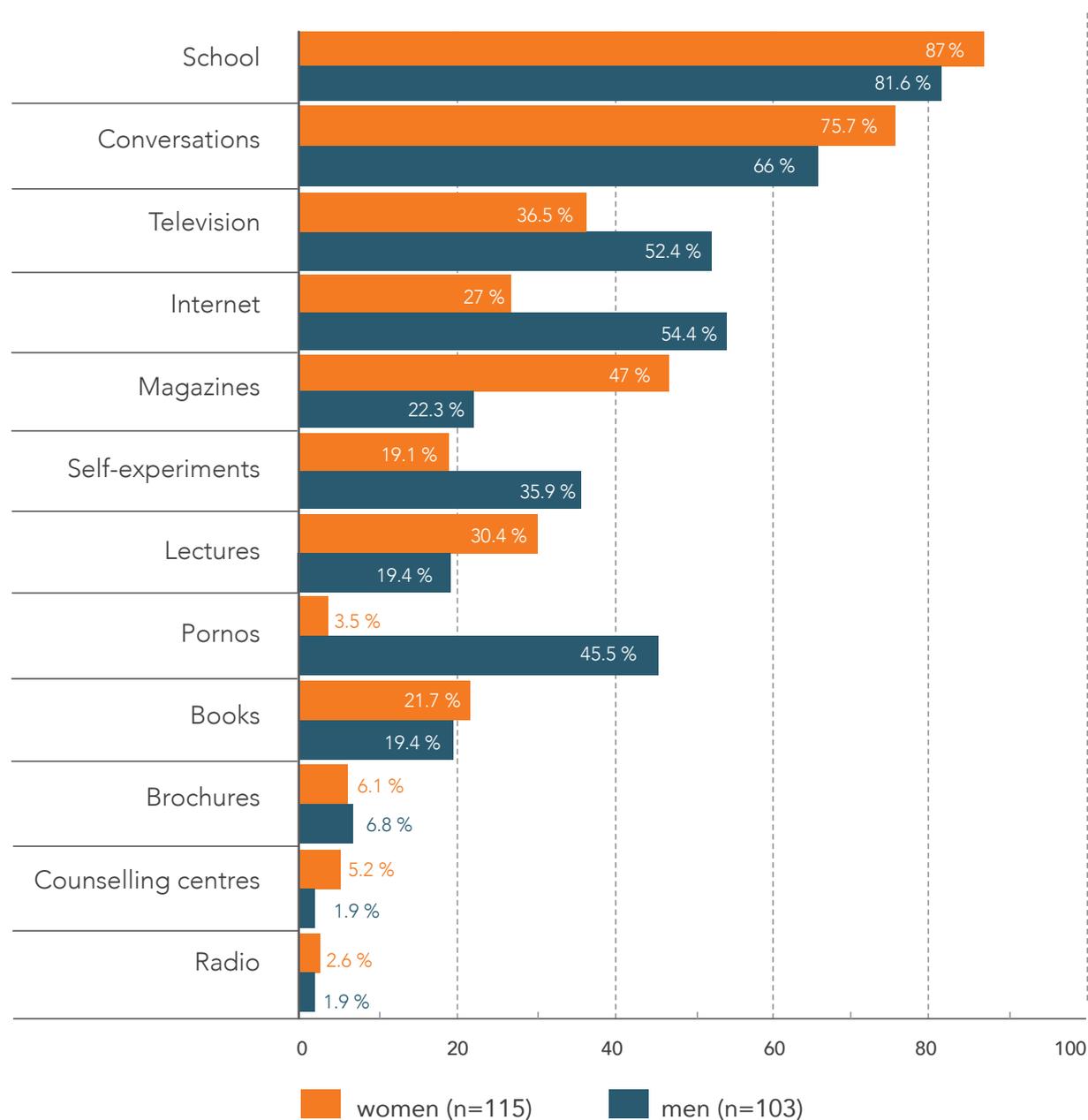
Figure 1 shows that the school is the most important source of information on sexuality for adolescents, whereas youth or family counselling centres are rather insignificant.

The second figure shows that friends are the most important source if asked in this way, and teachers come in third.



Austria

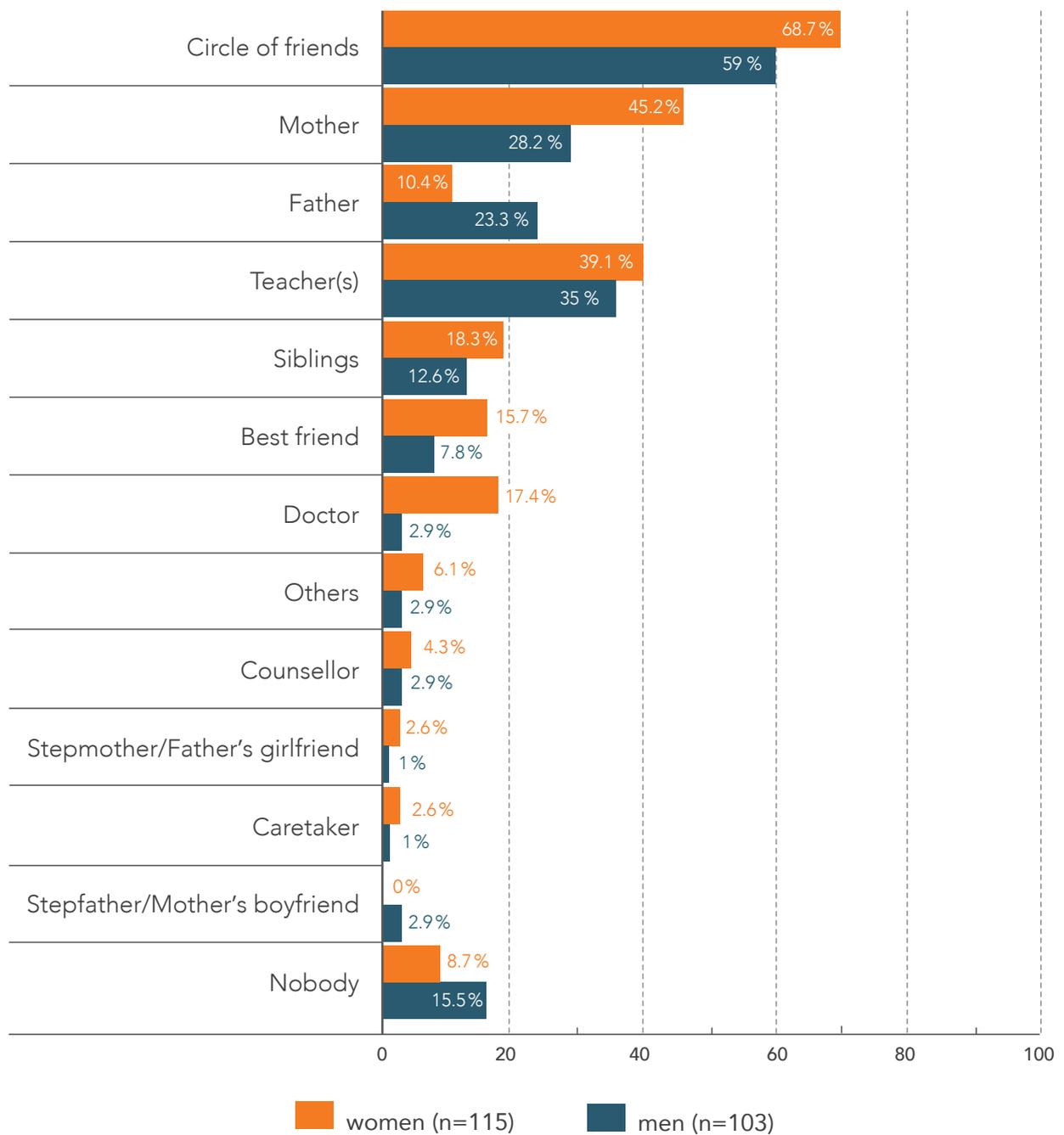
Figure 1: Sources of knowledge about sexuality\*



\* Taken from a 2012 survey<sup>16</sup> among young people between 13 and 19 years old (average ages: girls 15, boys 16 years).

(Original caption text of figures in German was translated into English by authors of the report.)

**Figure 2: Important persons that have provided sexuality education\***



\* Taken from a 2012 survey<sup>16</sup> among young people between 13 and 19 years old (average ages: girls 15, boys 16 years).

(Original caption text of figures in German was translated into English by authors of the report.)



Austria

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- 3 See [www.firstlove.at](http://www.firstlove.at)
- 4 See <http://www.jugendinfo.at/publikationen/erster-sex-und-grosse-liebe/>
- 5 See [www.sexualpaedagogik.at](http://www.sexualpaedagogik.at)
- 6 See [www.selbstbewusst.at](http://www.selbstbewusst.at)
- 7 See [www.liebenslust.at](http://www.liebenslust.at)
- 8 See <http://www.rataufdraht.at/themenubersicht/sexualitat>
- 9 See <https://www.bjv.at/kinderjugend/sexualitaet/>
- 10 See <http://www.queerconnexion.at/>
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## BELGIUM (Flanders region)

In Flanders, the northern, Dutch-speaking half of Belgium, 'Relational and Sexual Education' is regulated by a 2010 decree that defines the goals and educational targets of this subject. It is integrated into wider subjects, including biology, science, religion and language. The schools develop the lesson plans and decide what should be covered. Sexuality education is not a controversial issue.





## Laws and policies on school sexuality education

Between 1997 and 2010, there were several Royal Decrees on goals in the school curriculum that require results and/or a commitment to improving pupils' knowledge, attitudes and skills related to sexuality. The latest decree (2010) includes learning objectives for sexuality education to be reached in secondary education<sup>1</sup>. It sets out developmental goals to pursue and targets to be achieved, both of which are defined by the Ministry of Education. The goals relevant to sexuality education are subsumed under what must be achieved in lessons about nature, science and social skills. The focus lies on enabling teachers to teach about relationships and sexuality. The decrees enable adherence to the WHO/BZgA *Standards for Sexuality Education in Europe* (2010), i.e. 'holistic sexuality education'. These standards are used in discussions on new curricula and as such mainly serve an advocacy purpose, though they also influence curricula.

## Organisation and implementation of sexuality education

### Responsibilities

The responsibility for education in Flanders lies with the regional authorities, in this case with the Flemish government. The government sends inspection teams to schools to monitor compliance with targets and developmental goals. Schools develop the lesson plans and decide on which topics should be covered. Schools also have a certain autonomy in deciding how and when they teach within the limits of the general targets and developmental goals.

Various groups and organisations, such as educational professionals, young people, religious groups (in religious schools), health professionals,

NGOs and parents, influence the teaching of sexuality education. In 2016, a broad debate invited anyone who had any interest in voicing their ideas on a new curriculum (i.e. not just on sexuality education, but on all subjects). A consultancy agency wrote the final report, which was then presented to parliament.

Parents can influence the teaching of sexuality education through their presence on the school council found in every school. It is recommended that parents participate in shaping the health policy of schools.

### Sexuality education in practice

Sexuality education lessons are mandatory for all pupils. The age at which pupils are confronted with what topics is not specified, however, and as a result there is variation in the age at which elements of sexuality education are taught. It generally starts before the age of 10 and may continue until age 16 or older. The total number of sexuality education teaching hours is not recorded.

The subject 'Relationele en Seksuele Vorming' (Relational and Sexual Education) is generally part of the health policy of schools. Sexuality is also integrated into several other teaching subjects (see above) and sometimes taken up in 'project weeks'. Schools decide where to integrate non-biological aspects of sexuality.

Topics that are included extensively in the curriculum are biological aspects of sexuality and body awareness, pregnancy and birth, contraception, STIs, and access to safe abortion. Issues taught more briefly are HIV/AIDS, love, marriage and partnership, sexual abuse and violence as well as domestic violence. These various topics are included in several manuals and

publications for use in schools. Representatives of NGOs are sometimes asked to give specific lessons, but budgets for this purpose are limited. There is no significant opposition to sexuality education in Flanders.

### Teacher training

Most teachers do not get specific training for teaching sexuality education, and not all teachers feel competent enough to teach the subject. Schools are supposed to make arrangements for teaching sexuality education in their own teams. Educational materials and teaching guidelines were developed on the initiative of publishers and NGOs, like the regional expert organisation Sensoa (IPPF member association in Flanders) and others. Materials and guidelines developed by NGOs reflect participatory approaches to sexuality education. It should be stressed that approaches used vary by teacher and by school.

### Monitoring and evaluation

Implementation of sexuality education is not externally monitored or evaluated, so it is not exactly known how it is being implemented.

Expert organisations feel that the curriculum could be clearer on what exactly is expected regarding sexuality education in schools; the government could also be more active in assessing what is actually being taught. It is also felt that there is still the need to pay more attention to the relational aspect and to the basic training of teachers.

### Sexuality education outside the formal school setting

Information and education concerning issues related to sexuality for out-of-school youth is provided through numerous other organisations and channels, but there is no systematic overview of such initiatives or of the topics addressed. Examples of such extracurricular initiatives may be found in youth centres and specialised youth-support organisations, like Sensoa. Radio and TV networks sometimes also report on youth sexuality. But much more important are the new digital media, including YouTube, vloggers and websites dedicated to youth sexuality. Vulnerable or high-risk young people (in particular, young LGBT people, those with physical and mental disabilities, young people living in correctional institutions and undocumented young migrants) are reached through special educational activities. Specialised NGOs focus on these specific groups and organise educational sessions for them. They use the available materials developed by non-profit organisations and often adapt these materials as needed.

### Good practices and initiatives

There are several ongoing good practices and innovative activities available to promote youth SRH in Flanders.

- ‘Weetewa’ (You Should Know): YouTube videos originating from a vloggers competition on different topics. The first two editions were on gender.
- ‘Tussen De Lakens’ (Between the Sheets): visual materials regarding the body, contraception, STIs and sexual violence.



- ‘Zanzu’: a multilingual website covering almost everything related to sexual health by icons and pictures and with very little text. The site, which was developed in cooperation with the BZgA, is particularly relevant for immigrants with insufficient Flemish language skills.
- ‘Het Vlaggensysteem’ (The Flag System): a guidance document facilitating discussion on boundaries in sexual behaviour within the school system.
- ‘Allesoverseks.be’ (Everything about Sex): a website for young people, with many stories and much information on almost everything related to sex and relationships.

### Youth-friendly SRH services

There is an (indirect) link between school-taught sexuality education and SRH service delivery for young people. The schools collaborate with ‘Pupil Guidance Centres’ (PGC) to provide services in the areas of learning and studying, school career, preventive healthcare and socioemotional development. They also organise the medical examinations that are obligatory in certain grades. PGCs cooperate with other external services within their network: welfare and health institutions, such as counselling centres for child abuse or for termination of pregnancy. Pupils, parents, teachers and school boards may request guidance, information or advice from a PGC, including on sexuality-related topics.

Various institutions offer youth-friendly SRH services, but many of them do not meet all the criteria of youth friendliness, such as easy accessibility and anonymity. They are integrated in broader health or welfare services, such as general medical practices, JACs (Youth Advisory

Centres), youth employment organisations, and CLBs (Centres for Student Support, connected to school groups). However, most services are not structured to allow for enough time to discuss personal matters. Consultations are refunded by health insurance companies, but they inform parents (for finance reasons) if the young person is registered as living with them. This enables parents to get information on their children’s visits to a doctor. Vulnerable young people who do not attend youth work activities are probably hard for professionals to reach.

Another barrier is that young people have to pay for some SRH services, including STI testing and treatment, gynaecological and prenatal care, and even contraceptive counselling. There are arrangements for avoiding such payments, but young people are rarely aware of them.

Oral contraceptives and IUDs can be obtained free of charge. Emergency contraception is available from pharmacies without prescription, but in the latter case has to be paid for, though with a prescription, it is free of charge. Condoms are for sale in drugstores, supermarkets and other places. Young people under 21 years are refunded about €3 per month for contraception, and this discount is given immediately, which makes most contraceptive methods rather cheap for them.

There is no fixed age of consent for obtaining contraception or an abortion. If the doctor decides that a young person is capable of making a proper decision, parents need not be informed. There are abortion services where one’s name is not recorded and anonymity is guaranteed.

## Some survey and vital data on young people's SRH

A 2013 survey among young people provided some information on youth SRH<sup>2</sup>. More than 50 % in the 16–17 age group has had sexual contact(s), and 90 % of them were using modern contraception (condom and/or pill). In the 20–24 age group, 98 % are sexually experienced. The prevalence of chlamydia in this age group is at 181 per 100 000 women and 41 per 100 000 men. 15 % of all HIV infections in Belgium are found in people under 25 years (in absolute numbers: 500). The teenage birth rate in Belgium is fairly low at 8.4 per 1 000 women aged 15–19 years. Data from the latest HBSC study (2016) among 15-year-olds indicate that 68 % use oral contraception, the second highest rate in Europe (after Germany). This confirms the above-mentioned survey result.

In a survey among 4 339 young people in Belgium aged 17–19 years<sup>3</sup>, it was found that biology classes had been a main source of information on sexual issues (85.9 % of the respondents).



Belgium

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## BOSNIA AND HERZEGOVINA (Canton Sarajevo)

Sexuality education and related issues differ widely within Bosnia and Herzegovina, depending on the region (called 'cantons'). This report deals only with canton Sarajevo, which is the only canton that to date has introduced sexuality education. The course, which has a comprehensive character, is optional.





## Laws and policies on school sexuality education

The development of school sexuality-education programmes started only recently. Presently no law relates specifically to sexuality education. Rather, a governmental strategy calls for teaching ‘sexual and reproductive health and rights’. The goal is the ‘promotion of sexual and reproductive health in the context of healthy lifestyles with the purpose of reducing the risk of sexually transmitted diseases, premature birth or acceptance of different opinions in the field of sexual and reproductive health; and to provide a higher level of knowledge in the field of sexual and reproductive health through formal and informal education’. This Strategy Paper was adopted in 2010 and updated in 2016. It is scheduled to be implemented in the context of the Law on Primary Education, which applies in the entire country. Sexuality education is part of Healthy Lifestyle Education (HLS), which includes five further subjects (‘chapters’). The official title of the sexuality education chapter is ‘Protecting Reproductive Health and Gender Questions – Development of Protective Attitudes and Values’. In this way sexuality education is included in formal education, which lies in the responsibility of the Minister of Education, Science and Youth of the canton Sarajevo.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education, Science and Youth established a working group for the development of HLS education. Various people participated in this working group and contributed to the development of the sexuality-education curriculum. The ministerial staff reviewed the drafts prepared by participants and recommended which parts of

the curriculum to include or exclude. Teachers, researchers and other specialists also reviewed and commented on the drafts. Young people were also involved in the testing and evaluation of the curriculum units. All SRH materials were then revised and approved by health professionals. The ‘Parent Council’ as well as individual parents also became engaged in the development and introduction of sexuality education. Their role was to advise on whether the curriculum would meet the needs of both parents and pupils. A ‘letter to parents’ that was then integrated into the Student’s Workbook was recommended by the parents’ representatives. Finally, one of the authors of ‘It’s All One Curriculum’<sup>1</sup> provided assistance in the development. The Ministry of Education, Science and Youth was also engaged in organising, supervising and implementing educational activities for school directors, school educators and psychologists as well as teachers. Together with the ‘Association XY’ (the national member association of IPPF), the Ministry provides technical assistance and capacity-building activities in preparing schools for the implementation of sexuality education. To this end, a ‘cantonal’ curriculum, including a teacher’s handbook and a student’s workbook, were developed, primarily by the Association XY. The *Standards for Sexuality Education for Europe* (2010) were used extensively for advocacy, the training of teachers and for curriculum development.

### Sexuality education in practice

The HLS curriculum is optional; it can be chosen as one of three options, the other two being ‘Religion’ and ‘Society, Culture and Religion’. Most pupils (presently more than 90%, though this share is decreasing) choose one of the other two options. The HLS curriculum pertains to the 5th through 9th grade (ages 10–14 years) and covers a total of 175 lessons of 45 minutes

each. In grades 8 and 9, the chapter on sexuality education is implemented over the entire 2 years; in grades 5–7, it is implemented only during part of the year.

Association XY experts were responsible for the development of learning outcomes and teaching strategies, curricula, and teacher’s manual and student’s workbook. As part of the introduction of sexuality education in formal education, the Ministry of Education, Association XY and UNFPA B&H organised sensitisation sessions for school directors and school educators from all primary schools in canton Sarajevo. Besides

the education background, these events enabled discussions about the introduction of the subject as well as about the steps schools have to take when starting implementation and work on improving the quality of implementation. During the education of teachers, these organisations were also engaged in evaluating and assessing teachers’/ school needs relevant to implementation. Their feedback was used to provide additional support through a Teachers’ Network, created with the support of Association XY.

The sexuality-education curriculum has a comprehensive character, as is shown in the table.

### Overview of topics included in the sexuality-education curriculum in the canton Sarajevo

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth		X	
Contraception (including at least three effective methods)		X	
HIV/AIDS	X		
STIs	X		
Love, marriage, partnership	X		
Sexual pleasure			X
Sexual orientation		X	
Gender roles	X		
Online media and sexuality	X		
Access to safe abortion in the framework of the national law			X
Mutual consent to sexual activity	X		
Sexual abuse/violence		X	
Domestic violence		X	
Human rights and sexuality	X		



There are direct links with SRH service delivery for young people. In different sections of the Student's Workbook, pupils are encouraged to visit and use existing youth-friendly centres, counselling centres and other health facilities. All trained sexuality-education teachers were introduced to the various youth-related SRH services, and some training sessions focused on explaining the relevance of SRH services for adolescent health. Teachers were encouraged to inform pupils of the accessibility of services. Finally, there are exercises requesting visits to medical institutions as well as their websites as a part of pupils' activities (research, interviews, etc.). The sexuality-education curriculum is complemented by school-based campaigns and by peer education.

### Teacher training

Almost all sexuality-education teachers are trained in special 2–3-day courses. However, a lack of financial support is seen as the main obstacle to organising more effective educational activities, which are important for the improvement of teachers' competencies. The Teachers' Network mentioned above provides various kinds of support for implementing different sexuality education-related lessons, most of which use participatory learning approaches.

### Monitoring and evaluation

As part of the development process, the curriculum has gone through four evaluations, carried out by the Association XY and one by UNFPA Bosnia and Herzegovina. The evaluations indicated that the HLS curriculum is based on modern and effective pedagogical standards as well as that the sexuality education chapter is an important and relevant part of HLS. The evaluation reports were used extensively to provide additional guidance

to the introduction and implementation of the curriculum.

The Ministry of Education, Science and Youth of canton Sarajevo is responsible for monitoring and evaluating sexuality education, but because of a lack of resources, these activities have not yet been implemented.

In summary, the introduction of sexuality education as a part of HLS education was a success made possible through several externally supported projects, including IPPF EN. These projects led to its recognition and integration in formal primary education. A Global Fund project succeeded in establishing an intensive collaboration between the government and civil society. However, after the Global Fund project ended, this collaboration declined.

### Sexuality education outside the formal school setting

There is a wide variety of extracurricular educational activities available. These include peer education, counselling in youth centres, TV programmes focusing on parents and other stakeholders, education through websites and articles in student magazines. Again, most of those activities are implemented by Association XY. There is also a sex-positive website ('Pazi Sex'<sup>2</sup>) that provides additional learning opportunities and counselling services for five Balkan countries including Bosnia and Herzegovina.

### Vulnerable groups and special services

As part of the Global Fund project, different NGOs were involved in SRH educational and service delivery programmes targeting various high-risk and marginalised groups of young people. This project ended in the first half of 2016; Association

XY is now one of the few NGOs that is continuing its work with these population subgroups.

### Opposition to sexuality education

The introduction of sexuality education met with opposition. Bosnia and Herzegovina is a traditional society, and many parents and other stakeholders fail to understand the positive outcomes of sexuality education. Such a lack of understanding influences their perception of the relevance of sexuality education. The Islamic political party has also been trying to exclude sexuality education from primary education for the last 2 years. Even within the Ministry of Education there is an informal group that works on limiting sexuality-education-related opportunities, and advocates its total elimination. The same is being tried by teachers of 'religion', an alternative option to sexuality education.

### Challenges and recommendations

In order to strengthen the position of sexuality education and to improve its quality, the following future actions are recommended:

- strengthen and continue teacher training;
- establish an E-learning platform for teachers;
- develop additional teaching tools and guidelines;
- educate parents;
- establish a national policy on sexuality education;
- raise public awareness on the relevance of sexuality education for adolescent health.

### Youth-friendly SRH services

Youth-friendly SRH services are available in only two centres operated by Association XY. These are registered as part of government institutions but are financially supported by IPPF EN. SRH services for the general population are available through the Primary Health Care System, but they are not directed specially toward the young. Young people who use these services must visit different clinics to get different SRHR services, like STI testing, HIV testing and gynaecological examinations.

Young people have to pay for STI testing and treatment (but not for HIV), gynaecological services and induced abortion, which can pose a real barrier for them. In addition to this, contraceptive supplies have to be paid for. A study found that most oral contraceptives available in the commercial sector are unaffordable for the poorest 60% of the population. They are not subsidised for young people. Furthermore, the age of consent both for abortion and for contraception is 18 years.

Condoms can be bought in pharmacies, drugstores and supermarkets, but emergency contraception is not available without medical prescription.

(Sub-)national survey data on SRH of young people are not available. Bosnia and Herzegovina does not (yet) participate in the Health Behaviour in School-aged Children (HBSC) surveys.



Bosnia and  
Herzegovina



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## References

1 The Population Council (et al.) (2009). *It's All One Curriculum. Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV, and Human Rights Education*. New York: Population Council.

2 Pazi sex: <http://pazisex.net/hr/>

## BULGARIA

In January 2017, the topic of sexuality education was still in the political process of being introduced into schools. A new 2016 educational law included the topic, but it still had to be worked out in practice. Because of political instability in the country, it is uncertain whether sexuality education will in fact soon become part of school curricula.





Bulgaria

## Laws and policies on school sexuality education

The development of a new draft ‘Law on School and Pre-school Education’ commenced in 2014. The final draft thereof was adopted by the government at the end of 2015 and approved by parliament in 2016. The law includes an educational standard, though practical educational plans were still being developed at the beginning of 2017. An educational standard was developed for the subject of ‘Civil, Intercultural, Health and Environmental Education’, which includes ‘Health and Sexuality Education’. The latter sub-subject must be introduced via different carrier subjects, mainly biology and psychology. The subject of ‘Health’ is scheduled to be mandatory, but the curriculum on ‘Sexuality Education’ will be optional. It should be stressed that it is still uncertain whether the subject of ‘Health and Sexuality Education’ will indeed be introduced in all schools. Still, the 2016 law is more supportive of sexuality education than ever before (from a legislative point of view). The new standard was accepted after years of struggles and hearings in parliament. Yet advocacy efforts are still very much needed, because there is always a risk that the standard will not be followed up by a proper implementation plan. Currently, a ministerial commission is in charge of developing the latter, and the Bulgarian Family Planning and Sexual Health Association (BFPA; member association of IPPF) as well as some other NGOs are members of this commission, which deals with the standard implementation.

## Organisation and implementation of sexuality education

### Responsibilities

Local governments have a crucial role in the implementation of sexuality education. They have to submit a budget to schools for the implementation of the course on ‘Health and Sexuality Education’, which requires more advocacy efforts. This optional sexuality-education course is meant for secondary-school pupils from age 12 onwards. The curriculum is being prepared by the above-mentioned ministerial commission, in which universities, schools, NGOs, healthcare professionals and other institutions participate.

### Sexuality education in practice

The number of hours devoted to teaching sexuality education cannot be assessed, because only 1 hour per week is allotted, which also includes ‘civil and intercultural education’.

It is uncertain whether the final sub-curriculum on ‘Health and Sexuality’ will have a comprehensive character. A draft for this exists which is clearly comprehensive, but this draft still has to be discussed. The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) are being used in this process, both for advocacy purposes and for curriculum development.

In January 2017, the proposed curriculum for sexuality education looked as follows:

Parents are sometimes asked for their consent for in-school and extracurricular educational

### Proposed sexuality-education curriculum, under discussion in January 2017

Main topics dealt with	How extensive?	
	Extensive	Briefly
Biological aspects and body awareness	X	
Pregnancy and birth		X
Contraception (including at least three effective methods)	X	
HIV/AIDS	X	
STIs	X	
Love, marriage, partnership	X	
Sexual pleasure		X
Sexual orientation		X
Gender roles		X
Online media and sexuality		X
Access to safe abortion in the framework of the national law	X	
Mutual consent to sexual activity	X	
Sexual abuse/violence	X	
Domestic violence		X
Human rights and sexuality		X

To date, NGOs, peer educators and other partners are conducting the sexuality-education sessions in the schools. They also provide information on available SRH services. This information is also provided via social media and websites. Some schools deliver sexuality education quite extensively, whereas other schools provide little or none at all. It depends on the school administration, preparation and goodwill as well as the existing competencies of school authorities and teachers.

activities. Some sessions are organised together with them, especially when it concerns young people with learning disabilities or, for instance, when the topic is internet bullying. In other cases, parents are not closely involved.

#### Teacher training

Some teachers have already been trained in sexuality education as part of ongoing pilot programmes, implemented by UN organisations and NGOs. In the future, teachers are to be



Bulgaria

trained in universities as part of their preparation as new teachers.

Training and teaching materials were developed in the context of pilot programmes of UNFPA, other UN agencies, BFPA and other NGOs, but their use is not yet mandatory. These materials reflect a comprehensive approach and participatory teaching methods.

Because sexuality education is not yet formalised, there is no monitoring.

### Sexuality education outside the regular school setting

Several organisations are involved in extracurricular sexuality education. The Red Cross and Y-peer organise sessions on SRH in general as well as on prevention of sexual ill-health. BFPA provides lessons on general SRH, and the Bulgarian Centre for Women focuses on gender issues. There are websites with SRH information, such as the platform Loveguide.bg and the BFPA website Safesex.bg. Furthermore, attention is paid to the educational needs of various vulnerable and high-risk groups. The BFPA has developed guidelines for young people with disabilities. The BFPA and the National Network of Health Mediators also developed guidelines for young Roma and, as part of a Global Fund for AIDS, TB, and Malaria programme, others developed guidelines for IDUs and LGBT people.

### Opposition to sexuality education

Three years ago, there was a strong opposition campaign – mainly by religious ‘Neo-Protestants’ – against the sexuality-education guidelines that had been developed – and two of the authors of the guidelines were even prosecuted. The Orthodox

Church is also opposed to comprehensive sexuality education. Their main objections concern the right to safe abortion and LGBT-related topics. Some ultraconservative organisations even oppose contraception, condom use and in vitro fertilisation.

### Challenges and recommendations

The BFPA recommends, first, that at least two academic centres be developed and supported to prepare and certify teachers of ‘Health and Sexuality Education’; second, that municipalities create budget positions and develop local strategies for sexuality education as a separate subject in schools. Finally, in the future teachers should be trained at university level as part of their preparation for teaching to deliver sexuality education.

### Youth-friendly SRH services

Some youth-friendly SRH services in Bulgaria are provided by NGOs such as BFPA and in a few cases municipal hospitals, inspired by UNICEF and the National Network for Children’s initiative for ‘child and youth-friendly hospitals’. Some services for Roma youth were developed under different programmes, such as the Norwegian Financial Mechanism, under the heading ‘SRH for youth from vulnerable groups’.

Most (general) SRH services are free of charge for those who are enrolled in the health insurance system (all Bulgarian citizens under 18 and all pupils up to the age of 26 are insured by the state). Contraceptive counselling is provided free of charge by the BFPA, albeit not in state facilities. Counselling on gender-based violence is provided by the ‘Animus’ association and other NGOs, but not by the state. Emergency contraception is available without medical prescription or other

restrictions from pharmacies, and condoms can be bought in various places. In 2016 there was a campaign on primetime TV to educate the population on condom use, conducted by BFPA, in partnership with the Durex condom manufacturer.

Contraceptives are not free of charge for young people, because they are not included in the health insurance package. Moreover, some social groups, like the Roma communities, are not covered by the health insurance system. The cost of contraceptives is a barrier for most young people. The BFPA is the only institution that provides condoms and IUDs free of charge – IUDs being the most widely used contraceptive method among Roma and rural women. The age of consent for contraception is 14 and for abortion 18. The Global Fund for AIDS, TB, and Malaria is currently withdrawing from the country, so that the voluntary counselling and testing for HIV and hepatitis B and C will become a challenge.

### Data derived from surveys

Young people rely mainly on (modern) media for information on sexuality. Friends and peers are also important for this. The school, however, plays a minor role, and parents hardly play any role. Young people would prefer that the role of the school becomes more prominent.

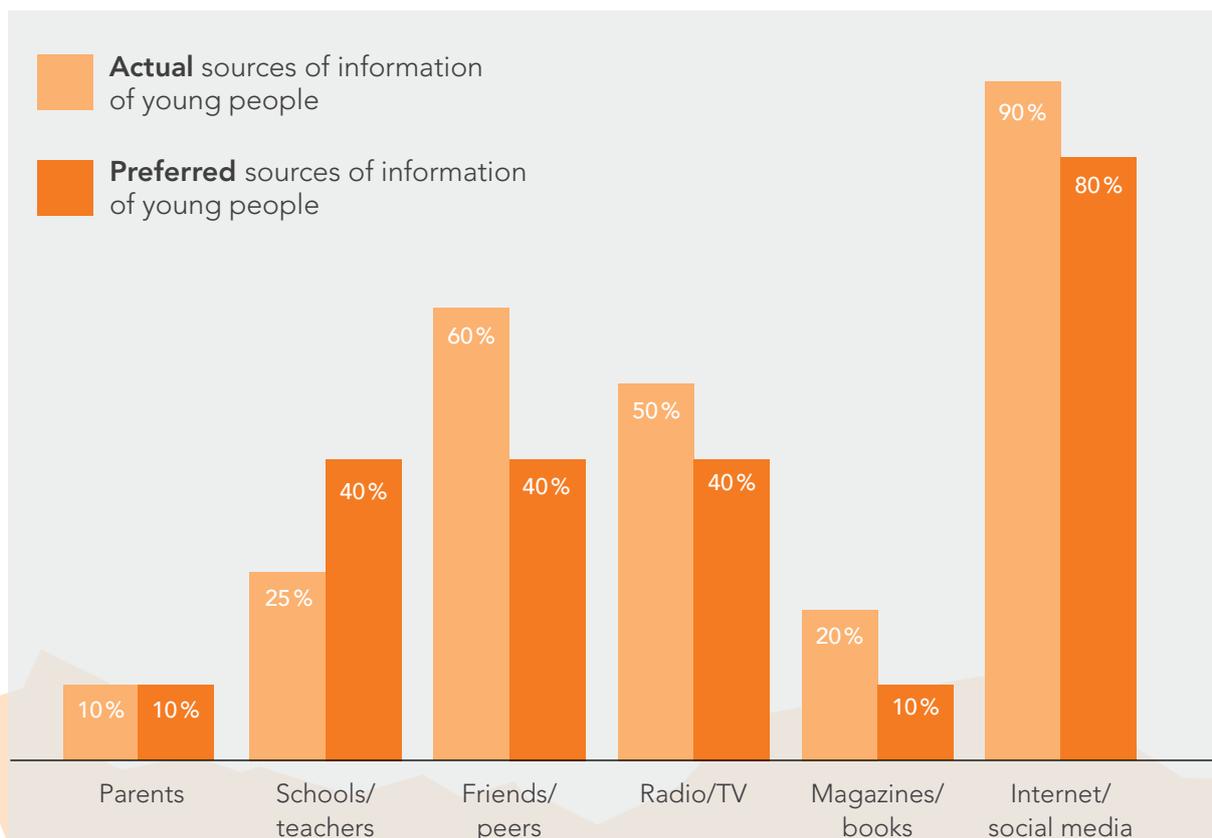
About 60% of adolescents under the age of 17 are sexually experienced, and of those only 40% used a modern method of contraception. Among the 18–29-year-olds, almost all are sexually experienced; in that age group the percentage using a modern method lies at just 40%.

Prevalence of HIV is low: in 2016 there were no diagnosed cases of HIV infection among under-18s, and in the 19–29 age group the total number of newly diagnosed cases in the entire country was 66.



Bulgaria

### Actual and preferred sources of information for young people, on sexuality-related issues



Data collection year: 2011

Age group: 14–29 years

Source: Grekova M. (2012)<sup>1</sup>

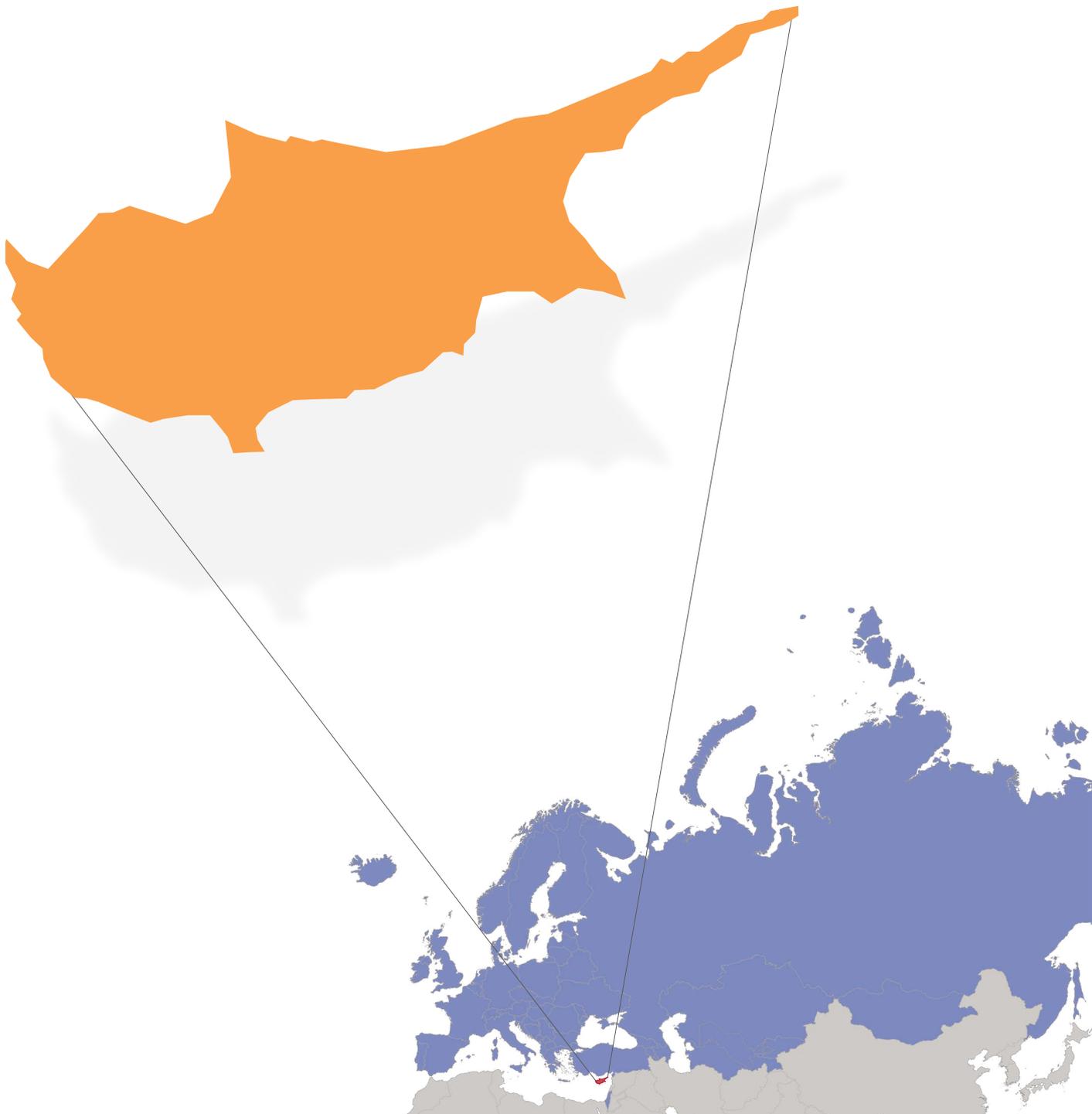
The survey questions were slightly different from the categories presented here. Therefore, the results are estimates. The percentages exceed 100% because respondents could give more than one answer.

#### Reference

1 Grekova M. (2012). Reproductive attitudes and behavior in Bulgaria (Analysis of results of representative sociological survey). Sofia: Bulgarian Family Planning and Sexual Health Association, UNFPA.

## CYPRUS

Sexuality education was first introduced in schools in Cyprus in 2011, when 'Health Education' was taken up as a new subject. Sexuality education became part of the thematic area 'Family Planning – Sexual and Reproductive Health', under 'Health Education'. In theory the programme has a comprehensive character, but in practice implementation has developed slowly. It is to be taught in primary and secondary schools to pupils aged 7–15 years.





## Laws and policies on school sexuality education

In 2010, a new educational reform was introduced by the Ministry of Education and Culture (MEC), whereby the subject 'Health Education' was introduced. In 2011, this led to the development of a health-education curriculum, which includes sexuality education in a thematic area entitled 'Family Planning – Sexual and Reproductive Health'. This area was developed in accordance with the WHO/BZgA *Standards for Sexuality Education in Europe* (2010). The health-education curriculum is being implemented by including elements of it in other teaching subjects, like biology.

Sexuality education is not directly regulated by law, but Cyprus has signed and ratified a number of international and European conventions, treaties and other agreements that promote and secure the right of children to sexuality education. In national laws, general references are made to the responsibility of the MEC to provide children with information on sexuality and to provide training for educators. These national laws concern (1) violence in the family (prevention and protection of victims; 2000 and 2004), and<sup>2</sup> the Law on Preventing and Combating Sexual Abuse and Sexual Exploitation of Children and Child Pornography (91(I)/2014).

The description of thematic area 'Family Planning – Sexual and Reproductive Health' of the Health Education programme provides a detailed overview of what should be taught at the different educational levels. It should be taught in grades 2 (age 7–8 years), 3 (age 8–9 years), and 6 (age 11–12 years) of primary school, and in grades 1 (age 12–13 years), 2 (age 13–14 years) and 3 (age 14–15 years) of secondary school. In high school,

it is an optional course for grade 2 (age 16–17 years). Although in theory it is an outstanding and comprehensive programme, to date it has been insufficiently and inadequately implemented. The number of teaching hours is not defined.

## Organisation and implementation of sexuality education

### Responsibilities

The MEC is responsible for the curriculum. It is not known to what extent and how other stakeholders have provided input to it, nor is it known which topics are actually being addressed in practice. There is no evidence whether the parents of pupils have played a role in the development of the curriculum.

### Sexuality education in practice

Sexuality education in schools is still in the process of development. It is not taught as a separate subject, but as a cross-curricular one, subsumed mainly as part of biology and home economics classes in secondary education. It is compulsory in primary and middle schools and optional in high schools.

As mentioned above, sexuality education has been a mandatory subject since September 2011, when it was incorporated into the health-education curriculum, but this applies only to public schools. It is not mandatory for private schools to follow the curriculum of the MEC. There is no information available about the provision of sexuality education in non-public schools. Some of those schools, in particular those that follow the curricula of public schools, may include sexuality education, whereas others may include topics of sexuality education within their own curriculum. NGOs, especially the Cyprus

Family Planning Association (CFPA; IPPF member association), are regularly invited by both public and private schools to provide lessons or implement workshops on sexuality education, but the time available for this is quite limited. There are also cases in which NGOs collaborate with the MEC in the implementation of EU projects that include workshops and activities related to sexuality-education issues, such as sexual violence, gender-based violence, bullying, etc.

Some information is provided within the curriculum on available SRH services for young people. Most of them, however, are provided by NGOs, including references made to available helplines.

### Teacher training

No data are available on the number of teachers who have been trained to deliver sexuality education or on the content and length of such training. Teacher training to deliver sexuality education is not mandatory. The Pedagogical Institute (PI) of Cyprus, under the auspices of the MEC, occasionally offers optional training to teachers at all levels of education on issues related to sexuality education, sexual and gender-based violence, homophobia and other issues, usually in collaboration with NGOs. It also provides in-service training, through several compulsory programmes, and optional seminars/workshops. Its mission is to cater for the continuous training of teachers at all levels so as to assist them in their efforts for professional and personal development. The PI is also responsible for the development of the curriculum and for the design, development and production of teaching materials.

Teaching guidelines are provided as part of the curriculum. The CFPA has, in collaboration with the MEC and the PI of Cyprus, developed

two teaching manuals for teachers on sexuality education, one for primary schools and one for secondary schools. Other teaching materials developed by other NGOs on human rights, children's rights, gender and other issues are also available. Some educational materials are available from the MEC, in the form of planned lessons on specific issues. The educational materials developed by CFPA, which do reflect a comprehensive approach, are based on the health-education programme of the MEC and include interactive teaching methods.

### Monitoring and evaluation

There is no M&E system in place, and as a result sexuality education has not yet been evaluated.

### Sexuality education outside the regular school setting

There are a number of extracurricular sexuality-education activities and courses. Youth centres and clubs organise workshops on several issues and invite NGOs to implement them. Some of the issues addressed are relationships, gender, bullying, homophobia, STIs and contraception. Besides the CFPA, which is the leading NGO on SRHR in Cyprus, other NGOs are active in this field. The Mediterranean Institute of Gender Studies (MIGS), for example, implements programmes with young people using a variety of non-formal, experiential and interactive methods. Themes such as human rights, gender equality and intimate partner violence are central to these programmes. Furthermore, the MIGS provides specialised training and has published a number of training manuals for teachers and youth workers for prevention interventions for youth. The Association for the Prevention and Handling of Violence in the Family (SPAVO) deals with the subject of domestic violence. It operates a helpline



to provide counselling, support and information related to domestic-violence issues. It also offers individual support and therapy by psychologists and social workers and runs two shelters for women and their children. In addition, it provides prevention programmes including training targeted at children in schools and at educators, and it organises awareness-raising campaigns on domestic violence.

Sexuality education through the mass media, internet and social media as well as awareness-raising campaigns on SRHR are very rare. There are also no educational programmes targeting especially vulnerable or high-risk young people.

### Opposition to sexuality education

There is some opposition to sexuality education in Cyprus. A group of parents claim that teaching children about sexuality encourages them to become sexually active at an early age; that it puts them in danger; and that it lures them into corruption. Their activities are very visible. This group often reports its opposition to the MEC and also registers its complaints to the Commissioner for Children's Rights and other stakeholders. Some teachers are opposed to sexuality education, although they are not very visible. During the educational reform process, there was obvious opposition to the introduction of sexuality education by conservative groups, including the Church.

### Challenges and recommendations

According to the CFPA, the successful implementation of sexuality education within the framework of the health-education curriculum in schools requires the following:

- a commitment on behalf of the MEC to systematic and mandatory training and active support of teachers, principals and inspectors with respect to sexuality-education topics;
- provision of appropriate educational materials that are age-appropriate for children and young people and based on research and scientific data (evidence-based), in accordance with the World Health Organization (WHO) guidelines;
- safeguarding of children's and young people's rights by implementing the international and European conventions as well as national legislation;
- the design and implementation of a M&E system for the implementation of all success indicators of the health-education curriculum;
- securing of sufficient financial resources for implementing sexuality-education programmes.

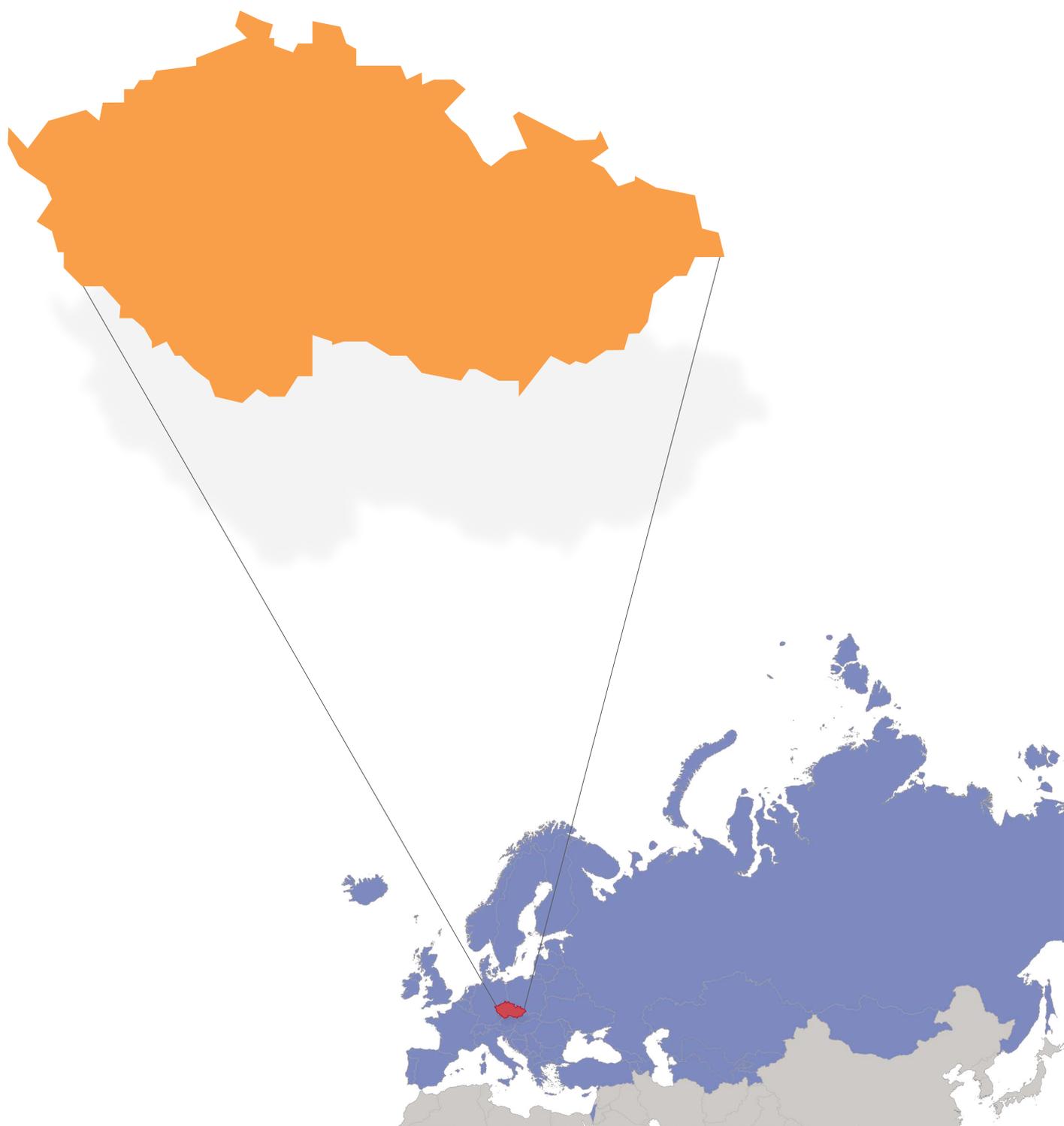
### Youth-friendly SRH services

Presently no youth-friendly SRH centres or clinics in Cyprus provide counselling or clinical services. Young people have to pay for SRH services, excluding testing and treatment of HIV/AIDS. Because most SRH services are provided by the private sector, the cost is probably a barrier for most young people. Contraception is not available free of charge. Emergency contraception is available without prescription from pharmacies, and condoms can be bought in supermarkets and kiosks. The age of consent for young people is 17.

There is a serious lack of data on SRHR of young people such as data on their sexual behaviour, the prevalence of abortion and STIs, access to and use of contraceptive methods, unwanted pregnancies and other issues.

## CZECH REPUBLIC

In 2004, sexuality education was included in the general law on school education and thus became mandatory, both in primary and in secondary schools. The schools have a fair degree of autonomy in deciding what exactly is taught. In 2016–2017 work on a national standard for sexuality education was still ongoing. A draft of this standard has a comprehensive character, but it is uncertain whether this will become the final standard.





## Laws and policies on school sexuality education

Sexuality education in the Czech Republic is included in the 2004 general law on school education, the 'Act No. 561/2004 Coll., Education Act', which regulates pre-school, basic, secondary, tertiary professional and other education at schools and school facilities. It lays down the conditions under which education and training are executed, defines the rights and duties of natural and legal persons involved in education, and specifies the scope of competencies of the bodies executing state administration and self-government in the system of education. Education in individual schools and school facilities is organised in accordance with School Educational Programmes. The Ministry of Education determines the content of Framework Educational Programmes (FEDs) for different levels of education. Part of these programmes is the mandatory teaching of sexuality education. Schools must comply with this obligation. The FED determines the content of education, including expected outcomes and curricula, but also allows for modification of the content of education and the extent and focus of teaching. The law, first adopted in 2004, is continually being revised according to the needs of society. The last revision dates from 2013.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education, Youth and Sports is responsible for developing the FED, though lately representatives of various groups have formed an expert working group led by the Ministry, which is involved in development and adaptation. The group includes teachers and educational professionals, religious and healthcare specialists

as well as representatives of NGOs. Schools are responsible for turning the FED into concrete curricula; local or regional governments are not involved. What is actually taught depends largely on the schools and the teachers, who decide how to address sexuality education and whether to include information on, say, modern contraceptive methods. Sexuality education should have a comprehensive character. It is included in the educational field entitled 'Man and His World' at the first level of primary schools and in the educational field of 'Health Education' at the second level of primary schools and in secondary schools. It is not taught as a separate subject. Therefore, the number of teaching hours for sexuality education cannot be specified. The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) were used (at a later stage) for the development or adaptation of the curriculum. National standards are still under development (see below) to specify and concretize the expected outcomes. 2016 saw a draft working version, which includes most of the topics of SRH and modern contraceptive choices for young people (see table).

### Sexuality education in practice

The curriculum must meet the mandatory targets resulting from the Framework Educational Programmes, but those are very general in nature. The relevant FED mentions the following goal: 'Basic education should help pupils create and gradually develop key competencies and provide a reliable foundation in general education, focused especially on everyday life situations and practical behaviour.' Schools select the methods and work formats and can extend certain topics. Parents do not participate directly in sexuality education in schools, but they should be informed about it. Although sexuality education is mandatory, it is also felt to be a specific and intimate subject, so that some parents may want to impart this knowledge

themselves to their children – or at least be the first ones to do so. Therefore, they may agree with the school on an individual approach to the issue. Schools can invite experts from NGOs to give lectures or undertake other activities. Because the contents of sexuality education are basically left to schools and teachers to decide on, there is substantial variation throughout the country.

The table gives an impression of the topics that are included in the draft national standard.

The draft national standard is a proposal of the working group. Although this group works officially under the auspices of the Ministry of

Education, Youth and Sports, it is not yet clear what will happen with the proposal. It is not set to go through an approval procedure, and it is also unknown whether it will eventually become a more or less formal national standard.

There are no systematic links between sexuality education and services for young people.

### Teacher training

Teachers are usually specially trained in 1-day training courses to provide sexuality education as required. Specialists and educators have developed educational materials and guidelines that have a

## Overview of sexuality education topic in draft national standard

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth	X		
Contraception (including at least three effective methods)		X	
HIV/AIDS	X		
STIs		X	
Love, marriage, partnership	X		
Sexual pleasure			X
Sexual orientation		X	
Gender roles		X	
Online media and sexuality	X		
Access to safe abortion in the framework of the national law		X	
Mutual consent to sexual activity	X		
Sexual abuse/violence	X		
Domestic violence		X	
Human rights and sexuality		X	



comprehensive character, as indicated in the above overview of topics. A participatory learning approach to sexuality education is partly used.

### Monitoring and evaluation

Only the process (but not the outcome or impact) of sexuality education is monitored by the Czech School Inspectorate. But because sexuality education is integrated into wider subjects, it is unknown how much attention is actually being given to this specific teaching subject. The Inspectorate can monitor the quality of the delivery of sexuality education in schools on behalf of the Ministry of Education, Youth and Sports and write a thematic report on the state of education.

It is recommended that assessment be continued to determine whether sexuality education, being a part of compulsory education in schools, is in fact being implemented.

### Sexuality education outside the regular school setting

Sexuality education outside the regular school setting is provided through youth centres and via radio/TV and other media. There are also programmes for vulnerable or marginalised groups, such as young LGBTI people, young drug users and sex-workers, and young people living with a physical or intellectual disability. These are programmes carried out by NGOs, but there are also some government projects in this sphere. NGOs, such as the Red Cross, SPRSV (IPPF member association) and others, implement educational activities for out-of-school youth on HIV prevention and contraception. 'Netopeer', a peer-education programme on these issues, is an example of this.

### Opposition to sexuality education

There is some opposition to sexuality education in the Czech Republic, mostly from religious families and from the ultraconservative opposition, such as the 'Committee for the Defence of Parental Rights'. Their main argument is that sex education is not the task of schools.

### Youth-friendly SRH services

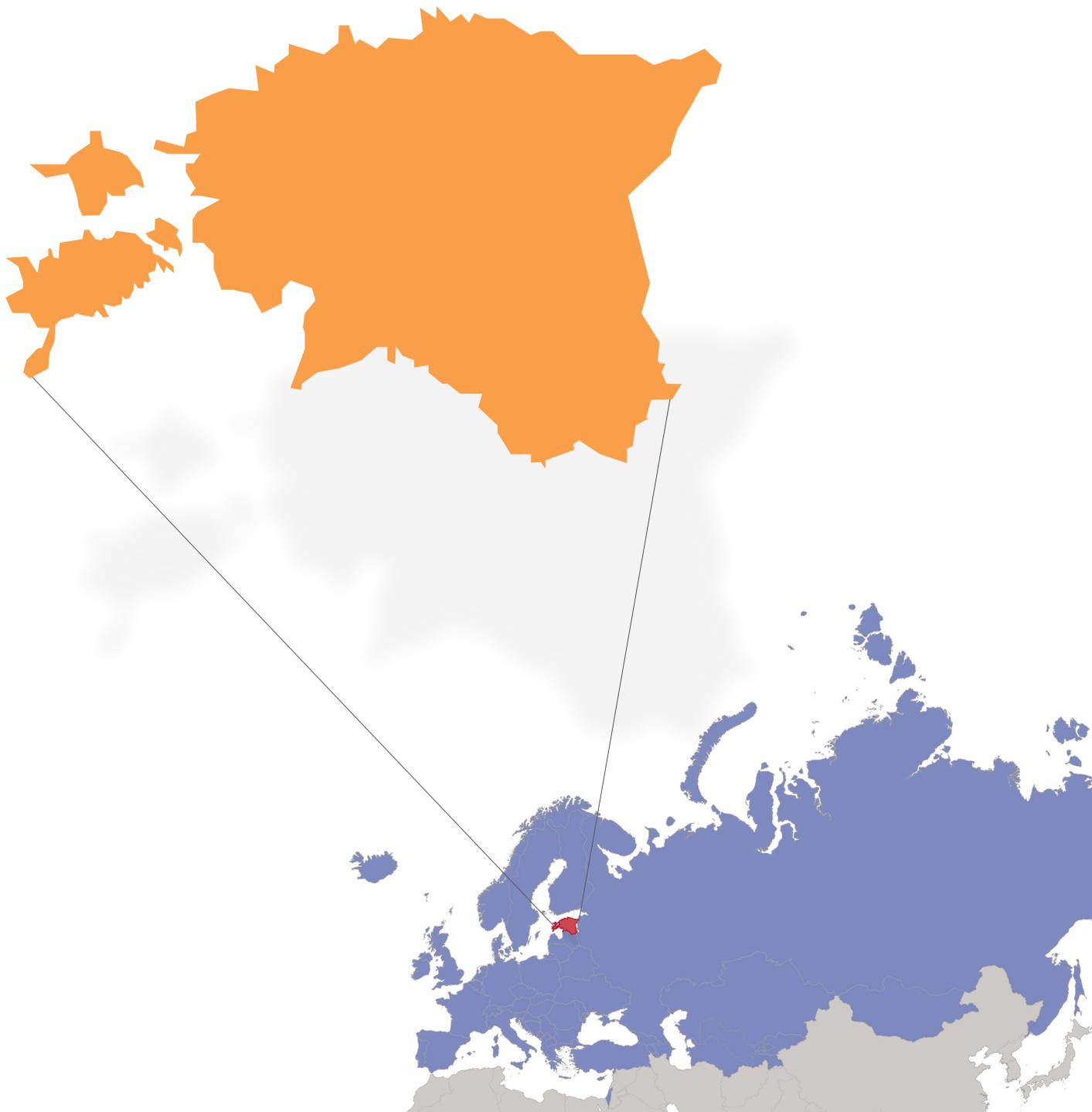
Gynaecological clinics are available for children and young people, run either by the government or by private providers, but there are no typical SRH information and service delivery centres for young people. SRH services are provided free of charge, so there is no financial barrier to services. Abortion as well as contraceptive supplies must be paid for, but there is no indication that this poses a serious financial barrier. Young girls and women over the age of 15 can obtain an abortion without parental consent. Emergency contraception is available without prescription from pharmacies, and there is no lower age limit to obtaining it. Condoms are for sale in kiosks, drugstores and supermarkets.

### Some survey and vital data on young people's SRH

There are no recent surveys among young people on SRH issues. Such data are available only through the 'Health Behaviour in School-aged Children' (HBSC) survey for young people aged 15 years. The latest HBSC report (2016) indicates that almost a quarter of the 15-year-olds have had sexual contacts. Most of these young people (about 70%) claim that they used a condom during their last sexual intercourse, and 30% of them said they had (also) used oral contraception. Data on STI and HIV rates for 15–24-year-olds are not available.

## ESTONIA

Estonia was the first country of the former Soviet Union to officially introduce school-based sexuality education (1996). Since then the sexuality-education programme has gradually been extended and implemented in all schools. The programme was influenced and supported by organisations working on sexuality education in the Scandinavian countries and the Netherlands. The Estonian programme is often presented as a model by international (UN) organisations like UNESCO<sup>1</sup> and the WHO<sup>2</sup>.





Estonia

## Laws and policies on school sexuality education

In 1996, sexuality education was included by law as a subject in the new curriculum for primary schools\*, replacing the old Soviet Union curriculum. The curriculum has since been adapted twice, in 2002 and 2011. Currently, there are two national curricula: one for basic (i.e. primary) schools and one for upper secondary schools, both of which were officially translated into English in 2014. The curriculum is part of the subject 'Personal, Social and Health Education' (PSHE; formerly 'Human Studies'), which also includes other life skills, such as the prevention of alcohol and drug addiction, and healthy nutrition. The official goals are to learn to develop and value knowledge, skills and attitudes that support personal development and socialisation in the following areas:

1. personal and social skills,
2. physical, psychological and social development,
3. health and healthy lifestyle,
4. safety skills and prevention of risky behaviour,
5. general human values such as honesty, caring for others, responsibility and justice.

Sub-goals for the different levels of basic school education which are closely related to sexuality education include the following:

Grades 1–3 (age 7–9 years): The pupils

1. value themselves and others and know that people's views, attitudes and values are different,

\* Primary School in Estonia has 9 grades, that start at age 7 and continue through age 16.

2. have necessary communication skills that take into consideration other people; they are able to verbalise their feelings and are able to choose appropriate ways of behaviour,
3. value friendship and supportive family relationships,
4. have knowledge about healthy ways of living,
5. know that you have the right to say 'no' to self-harming behaviour and how to find help.

Grades 4–6 (age 10–12 years); in addition to the previous goals:

6. value friendship and love in intimate relationships,
7. have efficient social skills in everyday life situations (helping each other, sharing, caring, cooperation); (...) have skills of efficient problem-solving and decision-making behaviour,
8. know about physical and emotional changes during puberty, accept that people mature differently.

Grades 7–9 (age 13–15 years); in addition to the previous goals:

9. know and plan healthy choices in everyday life,
10. know the meaning of sexuality and individual sexual development,
11. know the principles of safe sexual behaviour,
12. value sexual and reproductive rights,
13. know where to find information, help and SRH services.

In addition, there is the National Curriculum for Upper Secondary Schools that formulates objectives and compulsory or optional subjects for grades 10–12 (age 16–19 years). Finally, sexuality education elements are included in biology classes with the objective that ‘at the end of the secondary school pupils have knowledge about reproduction, contraceptive methods and know the concept of family planning’.

The sexuality education chapter covers about one fifth of the PSHE curriculum, but it is almost impossible to indicate this precisely because general skills (such as negotiating or decision-making skills) are relevant not only for sexuality, but also for dealing with other life challenges included in PSHE. The sexuality-education programme, implemented nationwide, has a strong comprehensive character and is mandatory for all pupils. A recent survey among women<sup>3</sup> showed that only 2% of 16–24-year-old women did not get sexuality education in school, and that roughly three-quarters of women felt that this education was sufficient.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education and Research is responsible for the curriculum, but the local governments, which own the schools, are responsible for delivering PSHE. In the process of the 2011 curriculum revision (performed by the University of Tartu in cooperation with members of the ‘Human Studies’ (PSHE) Teachers’ Association), the WHO/BZgA *Standards for Sexuality Education in Europe* (2010) were used extensively to promote the usefulness of sexuality education. The Estonian Sexual Health Association (ESHA, IPPF member association)

and the LGBT Association also contributed to the 2011 curriculum revision. Recently the *Standards* were also used to advocate for sexuality education at preschool age, at universities for medical students and teacher education, and in the education of other groups (youth-friendly SRH service providers, gynaecology residents, and policymakers).

Some schools organise workshops for parents, but they do not need any agreement from parents to provide sexuality education. Parents’ involvement in sexuality education is not substantial.

### Sexuality education in practice

Sexuality education starts in primary school, grade 2 (8-year-olds), where there are two lessons per week over the entire year. The programme continues in grades 3 and in grades 5–8 with 35 lessons per year, or about one per week. Most of the core parts that focus on sexuality, using a narrow definition, are delivered in grade 8, when pupils are about 14 years old, but they start already in grade 5. Altogether, there are  $6 \times 35 = 210$  PSHE lessons (of 45 minutes each) in basic schools, roughly one fifth of which consists of sexuality education, i.e. about 42 lessons (including personal and social competency topics). In the gymnasias (upper-secondary level), there is a mandatory course entitled ‘Family Studies’ and an optional one on ‘Psychology’.

During the entire programme, almost all relevant issues concerning sexuality and health are extensively dealt with in an age-appropriate manner, which gives the sexuality-education programme a rather holistic character. Furthermore, there is a strong emphasis on attitudes and the development of behavioural skills. Information is also provided about youth-friendly SRH clinics. Leaflets are distributed about services, and often teachers visit



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youth clinics with pupils for workshops. The close collaboration between school sexuality education and youth-friendly SRH clinics is understandable because the ESHA, the coordinator of the clinics, also played an important role in training teachers in sexuality education. The ESHA and the Medical Students' Association also give lessons in schools.

### Teacher training

Roughly half of the sexuality-education teachers participated in postgraduate sexuality education courses. During the years 2005–2010 many one-day teachers training courses took place, based on the Teacher Training Manual for sexuality education. The Manual and the short courses were initiated and financed by National Institute of Health Development. In addition, there were a number of 1-day courses on gender stereotypes as well as separate 2-day courses for Russian-language teachers. Currently, 1-day courses are also available on dating violence and healthy relationships. In-service training courses are still important, although future teachers now start to be trained in PSHE during their university course. The subject is included in the teacher training curricula of the universities of Tartu and Tallinn.

Various guidelines and educational materials for teachers and pupils have been developed, mostly by the National Institute of Health Development, teacher organisations, ESHA and Tartu University. Those educational materials reflect the comprehensive character of sexuality education and participatory learning approaches.

### Monitoring and evaluation

Population-based studies showed that sexuality education is associated, first, with improved sexuality-related knowledge of 9th-grade pupils and, second, with more effective contraceptive

use<sup>4</sup>. The sexuality-education programme has been evaluated extensively, particularly as part of a UNESCO study on the cost and cost-effectiveness of sexuality education<sup>5</sup>. The evaluation showed that the programme, in combination with the provision of youth-friendly SRH services, made a sizeable impact on the improvement of young people's SRH<sup>6</sup>. A wide variety of M&E reports is available on the internet (mostly in Estonian).

### Opposition to sexuality education

There is some hesitation about sexuality education. Most schools provide good-quality sexuality education, but some religious schools refuse to give science-based sexual education and instead prefer a morally judgmental 'sexual education', based on abstinence. Survey data indicate that Russian-speaking women received less sexuality education, and that Russian-speaking schools found sexuality-education topics 'more difficult'. (Russian-language schools represent less than a quarter of all schools.) It should be emphasised that schools are free to choose between different teaching materials.

Despite its success, the ESHA still feels that the quality of teacher training can be improved. Also, it should involve more new and young local sexuality-education experts and provide new approaches. International expertise can also be helpful, though Estonia is no longer dependent on it.

### Sexuality education outside the regular school setting

The ESHA organises extracurricular sexuality-education activities through its network of youth-friendly SRH clinics and its website. The Medical Students Association and the LGBT Association are also active outside schools, mainly through

their respective websites. The National Institute of Health Development and the ESHA periodically organise public awareness-raising campaigns on SRH issues. There have been some special projects aiming at educating especially vulnerable groups, including young LGTB people, drug users and sex-workers as well as for physically or mentally handicapped young people. There are also a few peer-education programmes, organised by the Medical Students Association.

### Youth-friendly SRH services

A network of 16 youth-friendly SRH clinics in Estonia has gradually been created since 1991. This number is high for a small country like Estonia with only 1.3 million inhabitants. The first clinic started in 1991 with support from Sweden, and most of the others were created in the second half of the 1990s. The clinics are free of charge for young people under 25 years old. Some of them work independently, and some are a part of state-run hospitals. Some are also part of private entities. The budget for these youth-friendly SRH clinics (also for the privately run ones) is provided by the state through the national Health Insurance Fund. If young people use state health facilities, they have to pay €5 per visit. If they go to private healthcare institutions, they have to pay much more for the services.

Young people have to co-pay for contraceptive supplies, the Health Insurance Fund paying half of the cost. The cost of contraceptives is not felt to be a serious barrier for young people. Induced abortion is also subsidised by the government, and as a result young people only pay one-third of the real cost, namely, €30 to €40, which can still be a barrier to some. For those under 15 years of age (rarely the case) the service is free. Emergency contraception is available without prescription or other restrictions from pharmacies (only one

type). Condoms can be bought in drugstores, supermarkets, etc. There is no age of consent for contraception, nor for abortion.

### Data derived from surveys

The table indicates that, by 2014, almost all young Estonians had received sexuality education in school.

#### Subjected to and level of appreciation of school-based sexuality education\*

Subjected and level of appreciation	%
Yes, too much	5.3
Yes, sufficient	71.0
Yes, too little	20.8
No, but would have wished	1.2
No, but would not have wished	1.0
Unknown	0.7
Total	100%

\* women 16–17 years old

Source: Lippus H., Lanpeere M., Part K., et al. Estonian Women's Health 2014. Tartu 2015.

The Estonian Women's Health survey<sup>3</sup> found that 50.6% of 16–17-year-old girls and 79.3% of 18–24-year-old women were sexually experienced. 16.5% of the younger ones and 15.8% of the older ones had not used any method of contraception.

In 2015, 1 351 cases of chlamydia were registered in Estonia, among them 824 cases among persons under age 25. There also were 121 registered cases of gonorrhoea, 63 of which among persons under



Estonia

age 25. A considerable proportion of chlamydia and gonorrhoea cases (two-thirds) had been diagnosed in the youth-friendly clinics. Data from the national HIV/AIDS register indicate that the percentage of 15–24-year-olds in the total number of diagnosed HIV cases has declined from 78 % in 2000–2001 to just 11 % in 2015, which is remarkable.

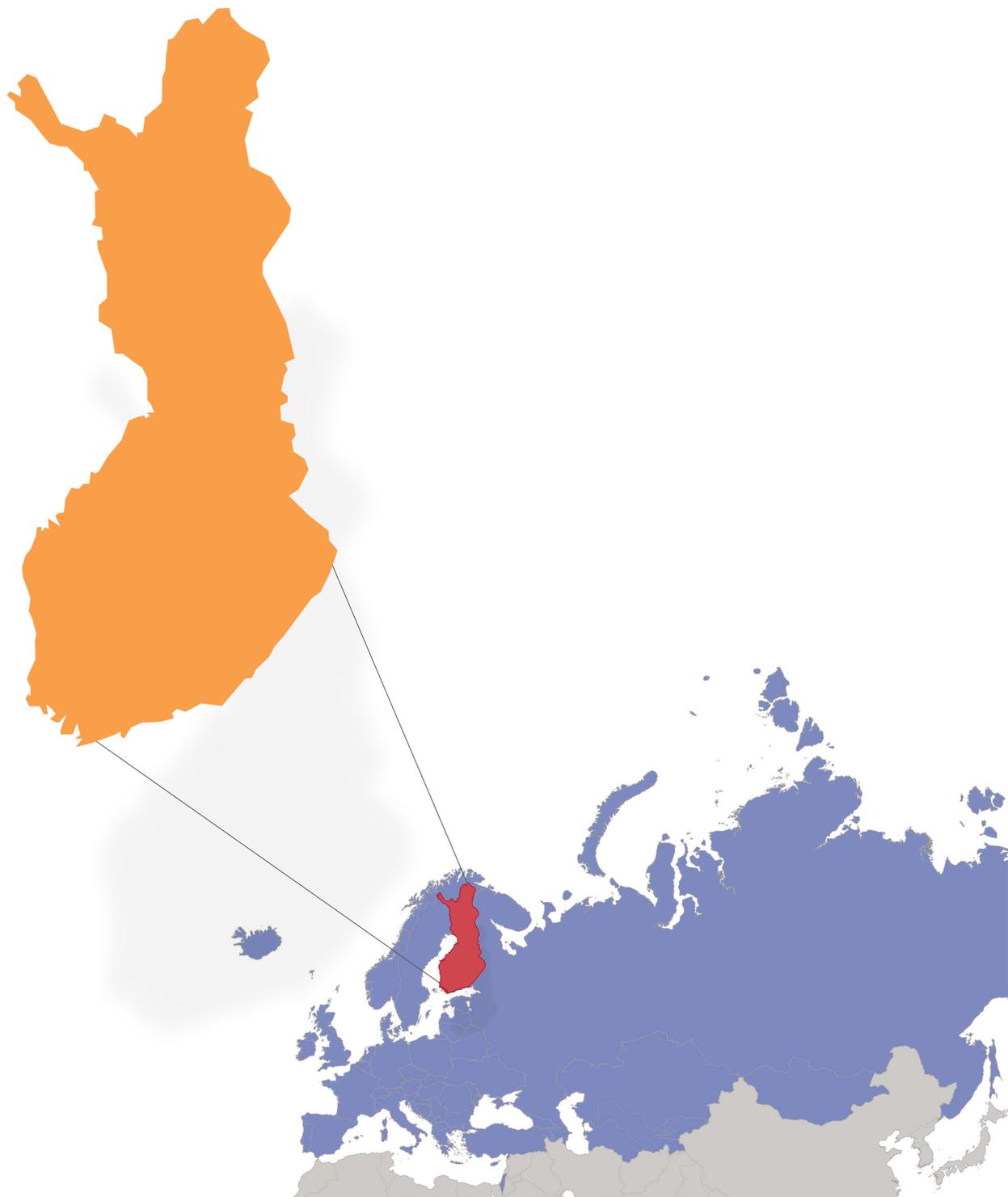
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## FINLAND

Sexuality education is a mandatory subject in all primary and secondary schools in Finland; it is generally integrated into broader subjects that are mandatory. Implementation varies in practice because municipalities and schools have a certain degree of autonomy in this matter, but it is always comprehensive in character. There is hardly any opposition to the subject.





Finland

## Laws and policies on school sexuality education

There are national-level core curricula and qualification requirements related to sexuality education in Finland which are enacted by the Finnish National Board of Education. They define the objectives and core contents as well as the basic principles of cooperation with families of pupils. They also define the objectives of pupil- and student-welfare services. The current core curriculum for basic (i.e. primary) education includes elements of sexuality education in the subject 'Environmental Studies', which is taught in grades 1–6 of primary schools (7–12-year-old pupils). The core curriculum for secondary schools, where sexuality education is integrated, is called 'Health Education'. This is implemented in grades 7–9, when pupils are about 13–15 years old. The main focus on sexuality lies in grades 8 and 9. Health Education is a separate subject with the contents: growth and development supporting health; factors supporting and harming health and prevention of illnesses; and health, communities, society and culture.

The current primary school core curriculum was issued in 2014; the curriculum for secondary schools and for vocational schools stems from 2015. These curricula are revised approximately every 10 years. The current ones are adapted from those issued in 2006. The overall goal of sexuality education in these curricula is to familiarise pupils, in an age-appropriate manner, with sexuality, different aspects of sexual health, and the diversity of sexual development. The national core curricula set a normative framework, which is both comprehensive and age-appropriate. Local providers of education transfer the core curriculum into a local curriculum and then implement it. For this reason, there is some degree of regional or school variation, which makes it difficult to state

exactly how many hours of sexuality education are included in the two curricula.

The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) provided the basis for the development of the current national core curricula for primary- and secondary-level education. Sexuality education is a mandatory subject, being included in Environmental Studies and Health Education, both of which are mandatory.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education and the Finnish National Board of Education are primarily responsible for curriculum (framework) development; the municipalities and the local schools are responsible for the local school curricula. Input to these curricula is also provided by teachers and educational experts, healthcare professionals and NGOs. This input is provided through working groups and advisory boards. The main NGO involved is the Finnish Family Federation ('Väestöliitto'; member association of IPPF), which is also active as an advocacy organisation for sexuality education. Parents are not systematically involved in the sexuality education teaching. NGOs sometimes provide lessons, but they are mainly responsible for developing and distributing materials to schools. Again, this differs by region or school.

### Sexuality education in practice

It is not possible to report exactly the extent to which different topics are being dealt with, seeing that schools have some latitude in this respect. All topics mentioned in the survey questionnaire are possible according to the national core curriculum.

The local curricula usually include most of them. Yet the teachers decide how much time they devote to the different topics. The table therefore can give only a rough impression of the contents.

The contents in terms of topics dealt with reflect the comprehensive character of the curriculum. Important aims of the national core curriculum are to learn to do research, find information, practise critical thinking and problem solving. This also means that during health education pupils learn where to find services and how to get access.

An interesting innovative initiative, started in 2016 and run by Väestöliitto, concerns a project in which young people actively take part in the development and implementation of a new model for sexuality education in schools, named 'Planning Sex Education with Pupils'. Working with specialists, secondary-school pupils gather topics based on what interests them and use this information to create the course content<sup>1</sup>.

Main topics dealt with	How extensive?	
	Extensive	Briefly
Biological aspects and body awareness	X	
Pregnancy and birth	X	
Contraception (including at least three effective methods)	X	
HIV/AIDS	X	
STIs	X	
Love, marriage, partnership		X
Sexual pleasure		X
Sexual orientation		X
Gender roles		X
Online media and sexuality	X	
Access to safe abortion in the framework of the national law	X	
Mutual consent to sexual activity		X
Sexual abuse/violence		X
Domestic violence		X
Human rights and sexuality		X



Finland

## Teacher training

All teachers are trained in sexuality education, because it is included in the university teacher-training programme. Health-education teachers often specialise in this topic, which includes 33 credits of university studies after the master of health science studies. Educational materials for sexuality education are available. They are developed by the National Institute of Health and NGOs active in the field. Commercial publishers are active here, too, but NGOs also develop materials. These materials emphasise participatory learning approaches and can also be used for other subjects, because this is a general guideline for all education.

## Monitoring and evaluation

There is no monitoring system in place, but from time to time some research is done to evaluate pupils' experiences with the curriculum. The Finnish Evaluation Education Centre arranges an evaluation of different subjects. The National Institute of Health also implements a school health survey every other year. One of the aims of the survey is also to evaluate the impact of sexuality education in schools. Health education was evaluated nationally in 2013 and included topics such as 'growth and development' and 'health in daily life situations', but not the content of sexuality education itself. The survey does not give the full picture because sexuality education is only a marginal part of the survey.

## Sexuality education outside the regular school setting

Various sexuality educational activities take place outside the school setting. Youth centres run by municipalities may organise sexuality education sessions on various themes. Specialised NGOs, like Väestöliitto, 'SexPo', 'Seta' and others, mainly provide information on their websites, as do commercial organisations. There are some educational radio and TV programmes.

## Vulnerable groups

Some programmes are directed at vulnerable groups. Those include LGBTI and HIV-positive young people, young sex-workers, out-of-school youth, those living with physical or mental handicaps, and young inmates of correctional institutions. These programmes are developed and implemented by several NGOs. The problem is that the work is mainly project-based, not long-lasting or permanent.

## Opposition to sexuality education

Until recently there was no significant opposition to sexuality education in Finland. However, some opposition and conservative thinking can now be found, and opposition has grown substantially in the last few years.

## Youth-friendly SRH services

Finland has many youth-friendly SRH services. In the major cities, there are specialised units for youth, whereas in rural areas these services are mostly integrated in other health facilities. According to the National Health Act, the municipalities are responsible for providing such services. Private providers and NGOs complement these services to some extent. The SRH services

are free of charge to young people, but they do have to pay for contraceptives, although some municipalities provide contraceptives for free. The cost can be a reason for not using contraception, or a young person may have to choose a more inexpensive method that is medically less suitable. For example, LARCs can be too expensive for some young people. At the moment, Väestöliitto and its cooperation partners are advocating for free contraceptives to be made available to all young people nationwide. Emergency contraception has been available from pharmacies without restrictions for young people since 2015, and condoms are very easily available. There are no legal age or consent restrictions for contraceptives and abortion. Doctors officially decide on the need for abortion.

### **Some survey and vital data on young people's SRH**

A 2015 survey among 16–18-year-olds indicates that 60% of them are sexually active and 67% of them use a modern method of contraception<sup>2</sup>. Based on the same survey it is estimated that about 0.9% of them have been infected with an STI. The HIV prevalence is 0.65 and 4.97 per 100 000 among 15–19- and 20–24-year-olds, respectively<sup>3</sup>.



Finland



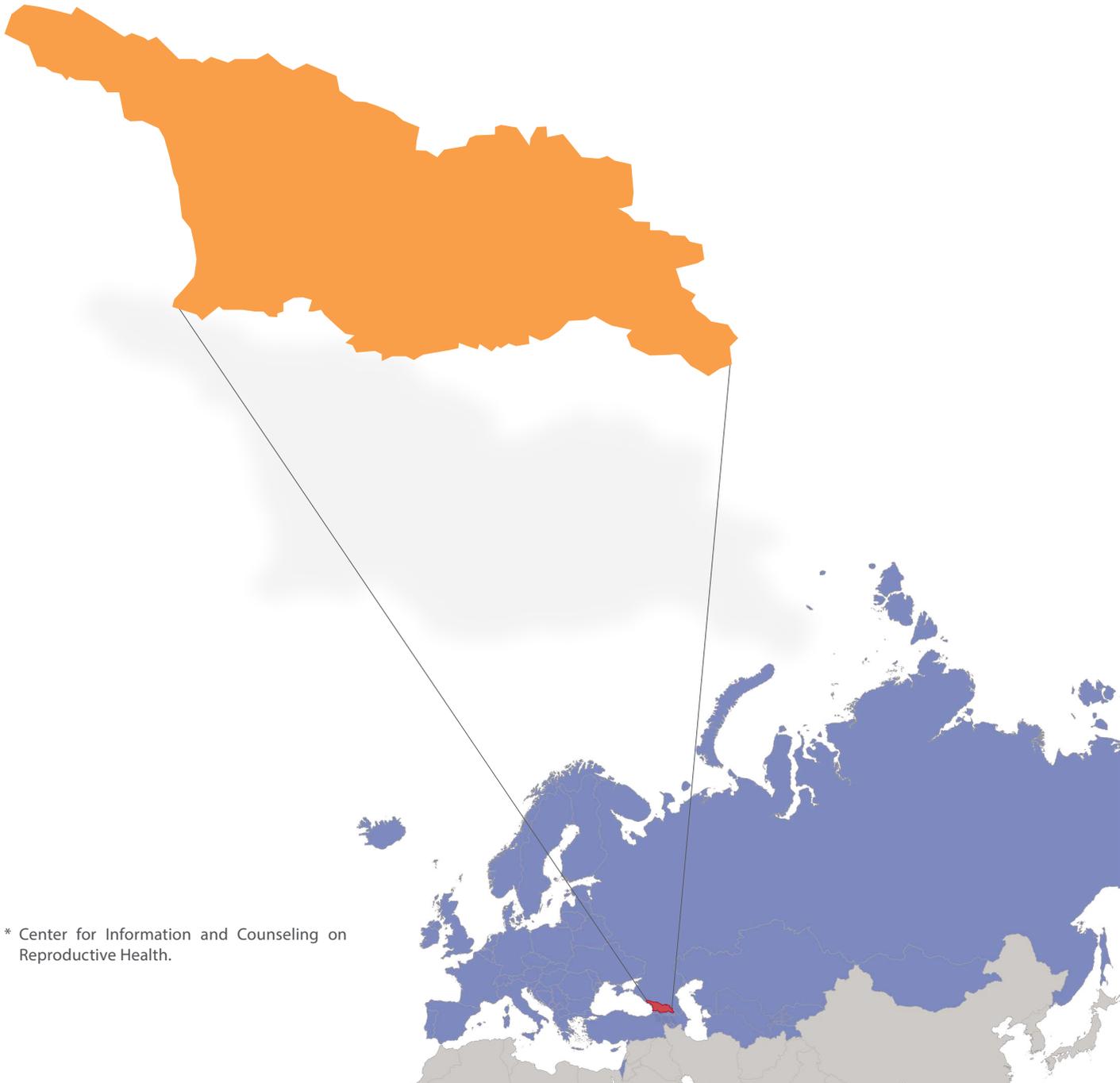
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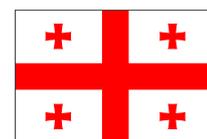
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## GEORGIA

Sexuality education is presently virtually absent from schools in Georgia. Still, the government is in the process of introducing Healthy Lifestyle Education, which is provisionally planned to include some sexuality-education topics. Active support for this development is provided by the UNFPA Georgia and by the NGO 'Tanadgom'\*. But it is still too early to predict to what extent sexuality education will indeed be included. There is strong opposition to it, especially from the influential Georgian Orthodox Church.



\* Center for Information and Counseling on Reproductive Health.



Georgia

## Laws and policies on school sexuality education

There are no specific laws or policies on sexuality education in Georgia. However, in June 2014 the EU signed an Association Agreement with Georgia, and according to articles 355, 356(c) and 368 of the agreement, the parties agreed to develop their cooperation in the field of public health, with a view to raising the level of public health safety and protection as an essential component for sustainable development and economic growth. The cooperation covers, among other things, such areas as prevention and control of non-communicable diseases, mainly through an exchange of information and best practices, and promoting healthy lifestyles.

Furthermore, concluding observations on the combined fourth and fifth periodic reports of Georgia to CEDAW\*\*, issued on 24 July 2014, emphasise there is an ‘absence of age-appropriate sexual and reproductive health and rights education’ and recommend the introduction of ‘age-appropriate sexual and reproductive health and rights education, including on responsible sexual behaviour, at all levels’. Based on these provisions, the country has some obligations. Thereupon, the Ministry of Education and Science publicly stated that it is going to incorporate Healthy Lifestyle Education (HLE) into the national school curriculum. Work on the curriculum started in late 2014, and a renewed version thereof for grades 1–6 was presented officially in 2016; it should be implemented starting in 2017. A new subject in HLE, ‘Me and Society’, includes some of the healthy lifestyle topics such as personal hygiene, healthy eating and sports. The development of standards and curricula is coordinated with CSOs and other interested parties.

\*\* Convention on the Elimination of all forms of Discrimination against Women, which is periodically being reviewed at country level through the UN system.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education and Science of Georgia is responsible for enacting HLE, which is still being developed with the assistance of the UNFPA Georgia. Despite the efforts launched by the state in the direction of HLE, it does not yet include specific topics on SRH and rights.

### Sexuality education in practice

A few sexuality education elements are included in the subjects biology, civic education and in a course on physical activity. Biology includes a topic on the male and female reproductive systems, which is mandatory because biology in general is. There are two lessons on this topic, taught to 12–13-year-old pupils, and together taking 3–4 teaching hours. Civic education includes more social and health topics: besides tobacco and drug use, also ‘relationship between family members’, ‘duties and responsibilities in the family’ and some gender issues. The physical activity course includes ‘personal hygiene and safety’ and ‘healthy lifestyle as a precondition for physical and mental health’. However, the physical activity course is in fact not implemented in most schools. Also, some biology teachers avoid or skip topics related to human reproduction.

Apart from the two chapters in the biology textbook on reproductive systems, several non-mandatory lessons on HIV and STIs were introduced to schools a few years ago. In light of this situation, it would be real progress if some SRHR topics were added. However, this does not mean sexuality education in the comprehensive

sense. The country is very slowly moving in this direction, albeit with much opposition and many setbacks – and with limited technical expertise and human resources. Cooperation between the government and the non-governmental sector is crucial to this process. National NGOs and international organisations (like UNFPA) are already making some efforts to provide more sexuality-education-related information, such as on sexual and reproductive rights, and on the prevention of pregnancy. And this applies only to a few schools they work with, as part of various projects and programmes. And to date this has not been centralised or adopted by the government.

### Development of a sexuality-education curriculum

As mentioned, a sexuality-education curriculum is still being developed under the aegis of the Ministry of Education and Science. Several working groups from the Ministry that include experts from local NGOs and international organisations are working on curriculum topics. Among them are expert teachers, staff of the National Centre for Disease Control and Prevention, UNFPA staff, and representatives of NGOs like Tanadgoma. The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) is one of the documents being used for this purpose. NGOs are already involved in piloting one of the subjects, ‘Me and Society’, under the title of Civic Education (for children 9–11 years old) in collaboration with the Ministry of Education and Science.

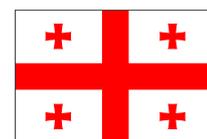
Representatives of the influential Georgian Orthodox Church, NGOs and a professional organisation of teachers are taking part in public discussions on the subject. It is still unclear which sexuality-education topics will be included in the HLE programme. The UNFPA Georgia has developed a draft curriculum for the programme,

which will be discussed with all involved stakeholders. It is planned to commence training teachers in 2017 when the new curriculum is scheduled to be introduced. Exactly how they will be trained has not yet been decided. Similarly, it is still too early to know what kind of teaching materials will be developed.

Interestingly, during the period just before 2010, a large and quite comprehensive UNFPA programme was launched, with EU support, that aimed at improving SRH of young people in Georgia (as well as in Armenia and Azerbaijan). It included several sexuality-education efforts that later turned out to be hardly sustainable. Around the year 2010 some surveys among young people were also conducted indicating that their SRH knowledge was poor. Tanadgoma conducted qualitative research among teachers, pupils and their parents. It showed, first, that teachers knew quite little about issues like STI/HIV/AIDS, abortion and contraceptive methods and, second, that they did not feel comfortable discussing reproductive health-related issues. However, they felt it was acceptable for teachers to do so if the school assumed the responsibility for SRH education. This survey laid the ground for CSOs and NGOs to start advocating the incorporation of basic SRHR topics in the educational system in Georgia. Later, with support of the UNFPA, the Ministry of Education and Science gradually started to move in this direction.

### Sexuality education outside the regular school setting

NGOs such as Tanadgoma and the IPPF member association in Georgia, HERA XXI, conduct educational sessions, using peer educators, on the prevention of HIV/STIs, on family planning, the prevention of early marriages, SRH and rights, gender, sexual health of minorities (e.g. LGBT)



Georgia

etc. Occasionally, radio and TV stations broadcast talk shows dedicated to some SRHR issues, and usually experts from NGOs participate in these, together with health and education experts. Educational programmes for vulnerable and high-risk groups are rare, but Tanadgoma does conduct training on gender and sexuality for LGBTI, including young people.

### Opposition to sexuality education

Quite strong opposition to sexuality education comes from the Orthodox Church, other orthodox religious movements and conservative social groups. Their arguments are that sexuality education runs against moral principles established in 'traditional' Georgian society and will cause defilement and debauchery in young people – and that 'sexuality education is LGBT propaganda'. For that reason, there is a need for more advocacy with the government as well as general sensitisation and awareness-raising in society, adherence to proclaimed European values and the adoption of recommendations from various international bodies, such as the Human Rights Council.

### Youth-friendly SRH services

There are few such services in Georgia. Some NGOs, like 'HERA XXI', provide such services in particular projects, based on the geographical location of those projects. Between 2006 and 2009, as part of the above-mentioned UNFPA project in three countries, several youth-friendly SRH services were created, but almost all of those disappeared again due to the privatisation of the healthcare system in 2008, which rendered those services unsustainable. As a result, young people had to pay for SRH services. Nowadays, young people must attend the same health facilities as the general population and, hence, pay the same

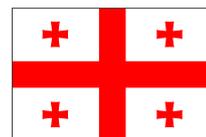
regular fees. Contraception is also neither free of charge nor subsidised for young people, which creates another barrier for them. Only if a service falls under some state-funded programme, is it free. Prices for services vary depending on the health facility. Overall, prices are high for both young people and for the general population. But the main obstacle for young people is that sexual activity of unmarried girls still carries a strong taboo, which makes it very difficult for them to attend any SRH service and, for example, ask for contraception there. Emergency contraception is available from pharmacies without prescription or other restrictions, and condoms can be bought in many places. The age of consent for non-surgical contraceptive and abortion service use is 14 years. According to the 'Georgia Law on Patients' Rights', underage persons (14–18) can receive surgical services without parental involvement if that person is psychologically competent (in the doctor's judgment) and is wholly aware of his/her health condition. However, anecdotal evidence suggests that young people very rarely use this possibility, the reasons varying from not being informed about this to sexual activity being very rare at the age of 14–15.

### Some survey and vital data on young people's SRH

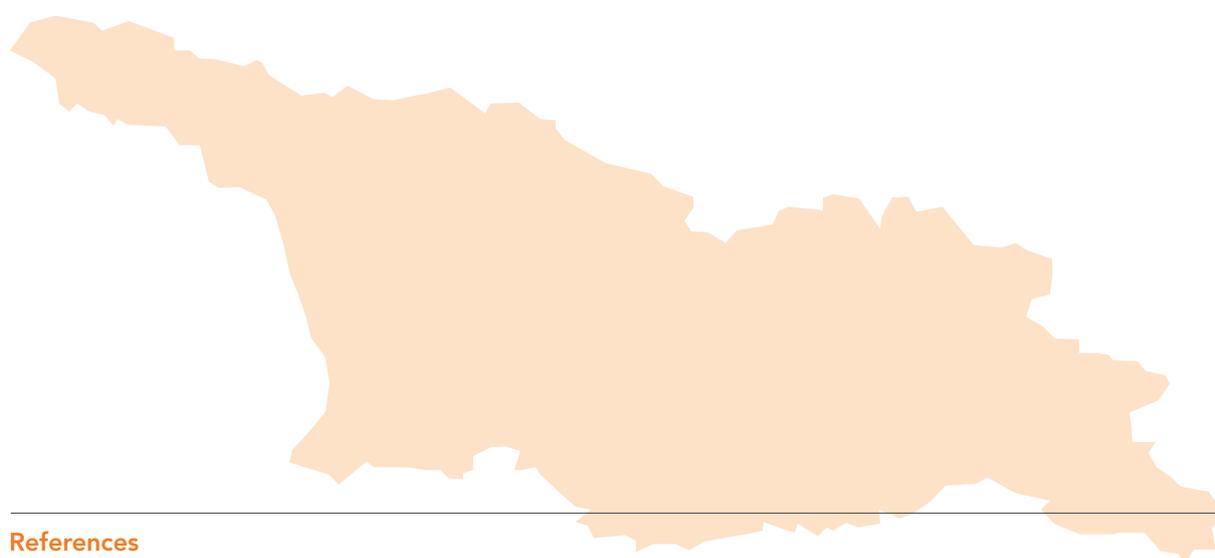
According to the Women's Reproductive Health survey<sup>1</sup> conducted in 2010, for young women aged 15–24 years, peers and friends were the most important sources of information about SRH issues (32%), followed by parents (23%), mass media (12%), school (10%) and magazines/books (9%). Data on preferred sources of information are not available.

A 2014 UNICEF survey<sup>2</sup> showed that young people (aged 15–29) are poor users of contraception, with only condoms being widely used.

Their knowledge of other forms of contraception (i.e. other than condoms) is generally very poor. The teenage birth rate<sup>3</sup> in Georgia (51.5 births per 1 000 women aged 15–19 years in 2015) is very high compared to other European countries. In fact, it is by far the highest of all the countries studied.



Georgia



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## GERMANY

Germany is a federation of semi-independent states (called 'Länder') that have some degree of autonomy regarding sexuality education. Still, there is a general (federal) framework for sexuality education as well as a national curriculum for it. Sexuality education is mandatory, starting in primary school, and it has a holistic (comprehensive) character. For young people the school is by far the most important source of information on sexuality.





Germany

## Laws and policies on school sexuality education

At the state level, sexuality education in schools is mandated by legislation and comes under the authority of each individual state. When sexuality education commences, how content is included in the curricula and which topics are emphasised may differ, depending on the Ministry of Education and Cultural Affairs ('Kultusministerium') of the respective state. However, in general, sexuality education is understood in a comprehensive way.

Laws and guidelines are supportive of comprehensive sexuality education; it is regarded as part of general education and hence as a relevant issue for all pupils in public schools. The laws strengthen the argument for teaching sexuality education in a holistic manner. In addition to transferring knowledge about contraceptives and biological processes, it must also address emotions and considers aspects of relationships and gender, different social and individual values, and aspects of communication. The laws also support collaboration between different actors working in the field.

Sexuality education is usually integrated in wider subject areas, including biology, ethics, religion and the social sciences. In very few states is it taught as a stand-alone subject. Sexuality education is considered to be a public remit. The Federal Centre for Health Education (BZgA), a government organisation, and the authorities of the 16 states are by law charged with implementing and conducting it, in close cooperation with German family counselling institutions and other NGOs working in the field.

Sexuality education is mandatory for all pupils in primary schools and up. Parents are informed before sexuality education classes begin in school.

However, they are not allowed to opt their children out. The content of sexuality education is age and development-appropriate. All the states have agreed on the general sexuality-education framework, which advocates a comprehensive and holistic approach. Because of differences between the individual states, the total duration of sexuality education teaching varies.

## Organisation and implementation of sexuality education

### Responsibilities

At the federal level, the BZgA is charged by law ('Schwangerschaftskonfliktgesetz', 1992, Act on Assistance to Avoid and Cope with Conflicts in Pregnancy) to provide sexuality education for different target and age groups, and to disseminate its materials free of charge to the general population and to certain stakeholder groups such as teachers and counselling centres. According to the principle of subsidiarity, the BZgA collaborates with NGOs in the field. To ensure a multisectoral approach, the BZgA is part of the portfolio of the German Federal Ministry of Health and is technically supervised by the German Federal Ministry for Family Affairs, Senior Citizens, Women and Youth. Together with the WHO Regional Office for Europe, the BZgA, being a WHO collaborating centre for sexual and reproductive health, developed the *Standards for Sexuality Education in Europe* (2010). There is presently also a 'Working Group for Curricula Development' in which teachers and educational professionals participate.

A national sexuality-education curriculum exists. At the federal level, the BZgA currently edits a framework concept on sexuality education, which was jointly developed by the BZgA and representatives of all German states; it was initially

published in 1994 and updated in 2016. The content of the *Standards* is integrated into the new version of the framework concept. At the state level, several sexuality education curricula for schools have been revised and elements of the *Standards* have been integrated into their curricula. At the community level, some NGOs (such as 'pro familia'; the national member association of IPPF) use the *Standards* as a basic document when training sexuality educators, in their advocacy work and in the development of sexuality education curricula.

### Sexuality education in practice

The table presents an overview of topics dealt with in the curriculum. The overview is based on a review of the official guidelines. In practice, the

topics approached and the intensity of discussion might differ among the different federal states and even among individual schools.

Information is given on how to access services. The state Ministries of Education develop guidelines and materials that are mandatory to use. Many schools invite NGOs or counselling services to come to schools to participate in the school-based sexuality education. There are also information events for parents, training for teachers/tutors in schools and other institutions, care for young people with disabilities, counselling for teachers, collaboration with social workers in schools and organised visits of school groups to counselling centres. Information is provided on different services provided by counselling centres as well as on (digital) helplines and hotlines. Information

Main topics dealt with	How extensive?	
	Extensive	Briefly
Biological aspects and body awareness	X	
Pregnancy and birth	X	
Contraception (including at least three effective methods)	X	
HIV/AIDS	X	
STIs		X
Love, marriage, partnership	X	
Sexual pleasure		X
Sexual orientation		X
Gender roles	X	
Online media and sexuality		X
Access to safe abortion in the framework of the national law		X
Mutual consent to sexual activity		X
Sexual abuse/violence		X
Domestic violence		X
Human rights and sexuality		X



materials are provided (for instance, pro familia brochures and BZgA materials), which are free of charge for educators.

### Teacher training

Only few teachers have been specially trained in sexuality education, though this varies throughout the country. For some of them it was included in their general studies. There are also some special courses and training programmes. For example, in Merseburg, the University of Applied Sciences offers a Master's degree programme entitled 'Sexology: Sexual Health and Counselling'; in Dortmund, the 'Institut for Sexualpädagogik' (Institute for Sexual Education) and in Frankfurt am Main the pro familia federal association provides training for sexuality educators.

### Monitoring and evaluation

Sexuality education has been evaluated extensively through the representative survey 'Youth Sexuality', which is repeated periodically (latest version 2015<sup>1</sup>). The results show a high level of knowledge, and school-based sexuality education is mentioned as one of the most important sources. Contraceptive behaviour is usually very good. Yet there are very few evaluations of individual programmes or parts thereof. No general monitoring takes place of the delivery of sexuality education.

### Sexuality education outside the regular school setting

A variety of educational activities take place outside school settings, in which NGOs play important roles. Besides pro familia, the following NGOs are active in this field: 'DRK (German Red Cross)', 'Caritas', 'AWO', 'Diakonie', 'Donum Vitae' and the German 'AIDS service organisation

(DAH)'. These educational activities relate to virtually all topics relevant to young people. They are implemented in youth (counselling) centres, by using (electronic) mass media (for example, special radio and TV programmes, the BZgA website 'www.loveline.de', and the pro familia site 'Sextra') social media, and via youth magazines. There are also programmes for young refugees.

Several efforts are directed toward reaching young vulnerable groups. There are three governmental 'concepts' including special target groups:

1. General Concept for Sexuality Education,
2. Concept: Sex Education for Youth, and
3. Sexuality education for persons with impairments.

The concepts are based on the principles of health promotion, i.e. they are not prescriptive, but rather emphasise strengthening personal competence. Several NGOs focus on these special groups. For example, the regional AIDS service organisations are active with young LGBTI people as are several other organisations as well, like 'Schlau'. Youth centres also address LGBTI people. There are information materials available for drug users (both print and digital) to prevent STIs, and sexuality-education programmes for young people with disabilities. Information materials are available in many languages. There are training courses for professionals in institutions for people with disabilities. Pro familia and the BZgA focus on an SRHR rights-based approach and publish easy-to-understand brochures (both print and digital) in many languages. It should be stressed that Germany works with an integrative concept of sexuality education that does not focus solely on individual target groups.

At the community level, a large number of governmental organisations and NGOs, with more than 1 600 counselling centres, work actively in the field of SRH and rights and mostly counselling is free of charge for adolescents and young people.

### Examples of innovative projects and programmes

- Get going: my strengths, my future ([www.komm-auf-tour.de](http://www.komm-auf-tour.de)) is an interactive career advice and life-planning service for young people. It provides new, activity-based incentives for supporting schoolchildren in the 7th and 8th grades of secondary school to discover their strengths and interests at an early stage. This service, the only one of its kind in Germany, links education and training with private life in a gender-sensitive way.
- [www.loveline.de](http://www.loveline.de) offers information about love, sexuality, contraception and partnership. This homepage is mainly frequented by boys and girls from about 12 to 17 years. The content, design and manner of address appeal to both sexes; gender-specific aspects are also dealt with. Readers get many answers and, for example, find the addresses of counselling services throughout Germany.
- [www.schule.loveline.de](http://www.schule.loveline.de) is a platform where experts can get information and materials for several topics.
- Join in circuit on AIDS, Love and Sexuality was a mobile intervention programme that toured from school to school. In an interactive format it enabled teachers, local cooperation partners and pupils to learn about sexuality in an open and communicative way. It also fostered the networking of organisations in the same locality.

The project ended 5 years ago, but a follow-up project is currently being developed.

- ‘Jetzt erst Recht. Menschenrechtsbasierte Sexualpädagogik mit Jugendlichen’. This consists of a pro familia guideline plus three training modules for rights-based sexuality education in schools. The thematic focus is strengthening the equality of the partners in sexual relationships.
- ‘Liebe und so Sachen’ (Love and such things) is a video film for young people with disabilities and their teachers, with a pedagogical handbook.

### Opposition to sexuality education

Although there is broad acceptance in Germany, there is also growing opposition to sexuality education, particularly from the AfD Party (Alternative for Germany). They argue that rights-based sexuality education furthers the early sexualisation of children, which they reject. They also strongly oppose the rights of LGBTI and gender diversity.

### Youth-friendly SRH services

Youth-friendly services in Germany, mostly provided separately, are available nationwide. They are run by the government, private providers or NGOs. Regular services are adequately youth-friendly, meaning that young people can, for example, access their regular doctor to obtain contraception.

The age of consent for contraception, emergency contraception and abortion is 14 years. Between 14 and 18 years the pharmacist/doctor decides whether parental consent is needed. Emergency contraception is in principle available without prescription from pharmacies. Condoms are available at many places and at a low price. Women



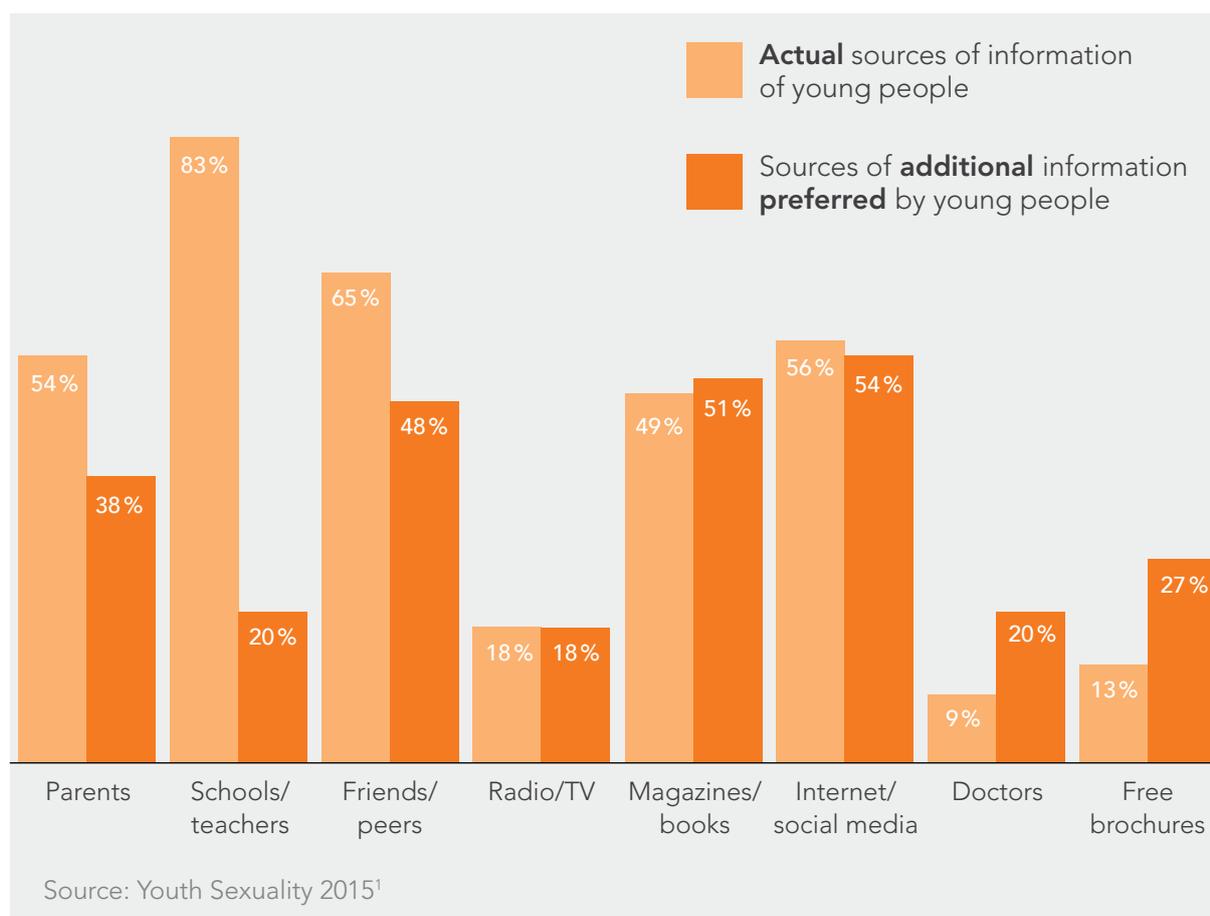
Germany

up to age 20 who are insured by the statutory health insurance can receive oral contraception ('the pill') free of charge.

### Some survey and vital data on young people's SRH

The latest national youth survey among girls and boys aged 14–17 years (2015) provides information on actual and preferred sources of information on sexuality-related issues (see graph).

#### Information on actual and preferred sources of information on sexuality-related issues



It is remarkable that school is by far the most important actual source of information; only one in five adolescents feel that the school should have provided even more information.

The same 2015 survey provides recent information on contraceptive use (see table):

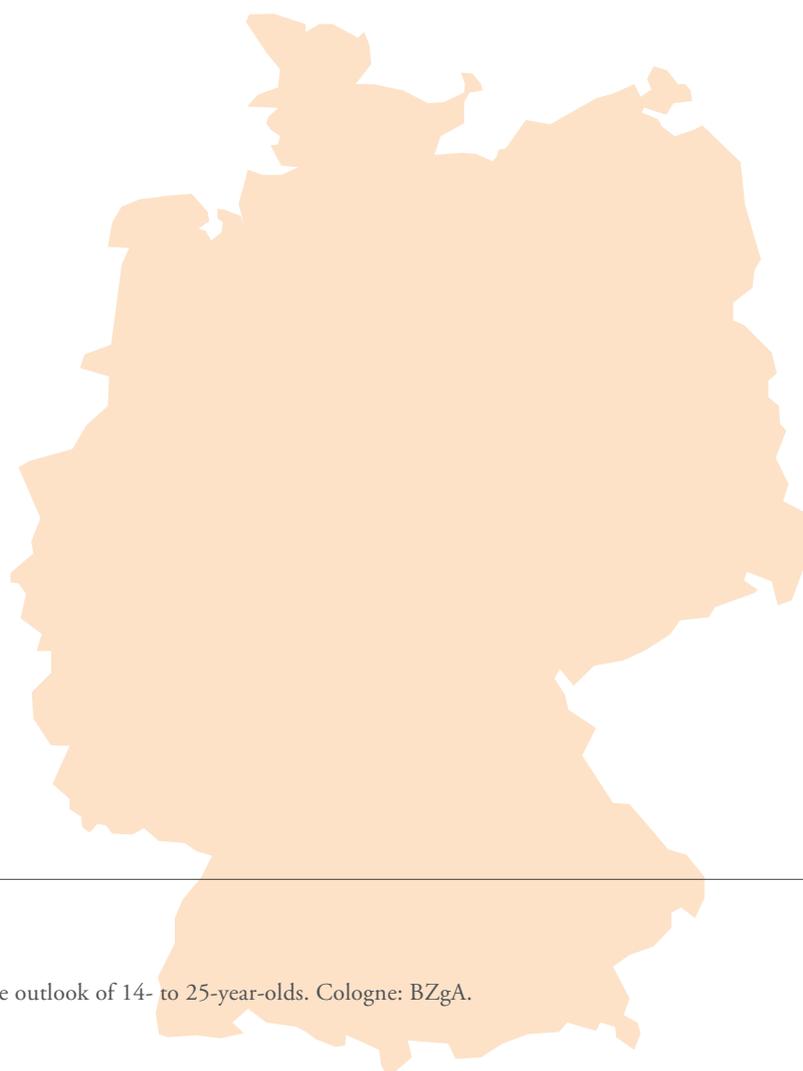
Age group	% ever sexually active	% use modern contraception
14–17 years	30 %	Condom: 57 % Pill: 72 %
14–24 years	67 %	Condom: 49 % Pill: 71 % IUD: 2 %

The data on condom and oral contraceptive use thus indicate that both methods are often used together.

In 2015, 13.5 per 100 000 young people (age 15–24 years) had been diagnosed with a syphilis infection. It is estimated that 4.5 % of 17–18-year-olds have a chlamydia infection. 16.8 per 100 000 15–24-year-old young people had been diagnosed with HIV; the latest national estimate is 29 per 100 000.



Germany



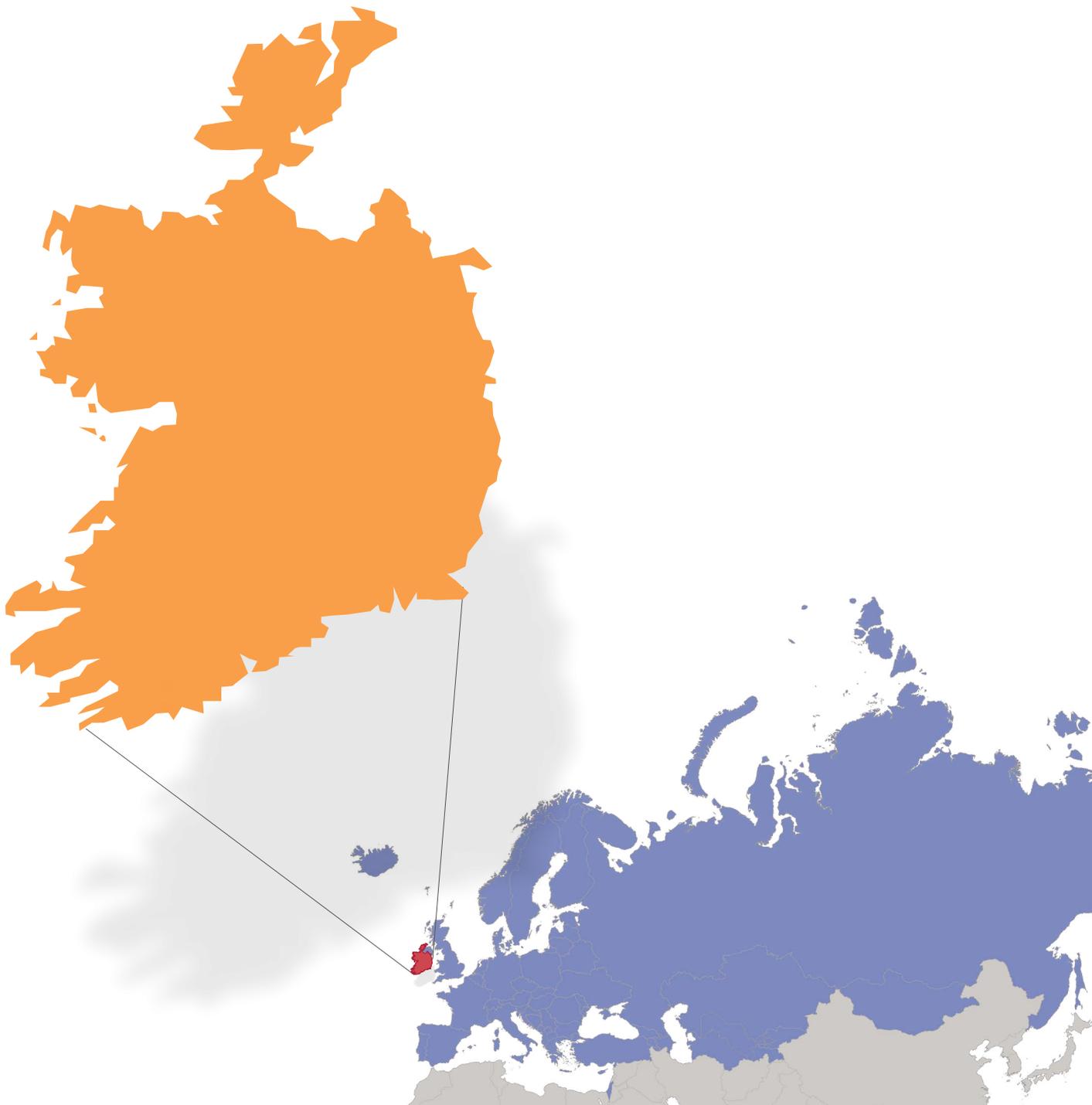
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### Reference

1 BZgA (2015). Youth Sexuality 2015: The outlook of 14- to 25-year-olds. Cologne: BZgA.

## IRELAND

Since 1998, sexuality education (referred to in Ireland as 'RSE,' relationships and sex education) has been a mandatory subject in both primary and secondary schools. The subject is mainly taught under 'Social, Personal and Health Education' (SPHE), which is mandatory. It is difficult to assess how comprehensive the programme is in practice. Experts feel it is 'abstinence + some prevention' in practice. The Roman Catholic Church, which tends to promote abstinence, has some influence in the teaching.





## Laws and policies on school sexuality education

Under the Education Act of 1998, schools are obliged to promote the social and personal development of pupils and to provide them with health education. Following the 1998 Act, a new curriculum was introduced called ‘Social, Personal and Health Education’ (SPHE). Sexuality education is one of the ten modules that make up the SPHE curriculum. The aims of SPHE are:

- To enable pupils to develop skills for self-fulfilment and for living in communities,
- To promote self-esteem and self-confidence,
- To enable pupils to develop a framework for responsible decision-making,
- To provide opportunities for reflection and discussion,
- To promote physical, mental and emotional health and well-being.

In addition to the 1998 Act, policies are updated through departmental Circulars, which are treated by schools as directives. The following Circulars have been issued since 1998 in relation to sexuality education:

- Circular 0027/2008 – reminds post-primary schools of their obligation to develop a policy on sexuality education and to implement a programme in this area as an element of SPHE in the junior cycle, and as an RSE (Relationships and Sexuality Education) programme in the senior cycle.
- Circular 0023/2010 – provides best-practice guidelines for post-primary schools on the

implementation of RSE, including guidelines on visitors to schools.

- Circular 0037/2010 – reminds post-primary schools (again) of their obligation to develop a policy on sexuality education and to implement a programme in this area as an element of SPHE at the junior cycle, and as an RSE programme in the senior cycle.

Under Section 30 (2)(e) of the Education Act 1998, a child may not be required to attend instruction in any subject that runs contrary to the conscience of the parent, or in the case of a student who has reached 18 years, the student. While there are guidelines on the content of RSE by the National Council for Curriculum and Assessment (NCCA), they are not binding, and schools can decide how to teach the content of the course based on their own moral or ethical considerations.

RSE is part of the SPHE curriculum, which also covers gender studies, mental health, substance use, physical activity and nutrition. It is sometimes taught as a stand-alone subject and sometimes in conjunction with other subjects, such as biology and religious education. The latter may result in young people receiving only information about the biological aspects of sex or being taught RSE within a religious framework.

According to the NCCA (1996), interim curriculum and guidelines for post-primary schools (13–15-year-old pupils), the following topics should be covered: human growth and development, human sexuality, and human relationships. For senior-cycle pupils (16–18 years old), only the first two of these subjects should be dealt with, albeit in more detail.

The programme consists of 5 hours per year in the junior and transition years. Although mandatory, it is possible to opt out. Currently a framework for monitoring RSE is not in place.

The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) has not been used for advocacy or curriculum development purposes.

## Organisation and implementation of sexuality education

### Responsibilities

At the governmental level, the Minister for Education and Skills and the Department of Education and Skills are responsible for this matter and for developing the SPHE curriculum. At the local level, all schools are required by the Department to develop an RSE policy and ensure that RSE is taught from the start of primary school till the end of post-primary school. According to the Department of Education's RSE Policy Guidelines (1997), each school's RSE policy should be developed in consultation with teachers, parents/guardians, members of the Board of Management and pupils themselves. According to the Department, the RSE policy should reflect a school's core values and ethos as outlined in its mission statement. Parents are not involved in sexuality education. Many schools invite external agencies for specific lectures or workshops. While this includes organisations such as the Irish Family Planning Association (IFPA, IPPF member association), which provides comprehensive sexual health information, conservative Christian agencies, such as 'Pure in Heart' and 'Love for Life', which advocate abstinence until marriage, can also deliver workshops in schools in the RSE programme.

### Sexuality education in practice

Despite significant policy and legislative progress, challenges remain in the areas of implementation, monitoring and evaluation. Specialists in the field think that, in practice, SRE is best characterised as 'abstinence and prevention of pregnancy and STIs/HIV'. It is possible for schools to comply with existing rules without providing young people with comprehensive evidence-based information. Sexuality education is not subject to the same degree of scrutiny by the Department of Education as other subject areas, in particular exam-based subjects, resulting in less departmental inspections of school policies and programmes in this area. Additionally, the services established by the Department of Education to support schools in RSE face many challenges, such as a lack of staffing and other resources.

Media reports have highlighted a lack of transparency of sexuality education. A 2014 investigation by a national newspaper found that most schools declined to provide basic information such as what textbooks they use to teach the programme and which groups visited to give talks or classes about relationships and sexuality. It also found that some schools are using textbooks that exclusively promote abstinence, that claim condoms have a high failure rate and that fail to mention homosexuality.

This presents difficulties in providing evidence-based sexuality education which are related to the fact that the vast majority of schools in Ireland are faith-based, as reflected in the schools' mission statements. The table presents an overview of the curriculum as it is planned.

In practice, the character of sexuality education depends on the type of secondary school in



Ireland

Main topics dealt with	How extensive?			
	Extensive	Briefly	Not	Don't know
Biological aspects and body awareness	X			
Pregnancy and birth	X			
Contraception (including at least three effective methods)		X		
HIV/AIDS	X			
STIs	X			
Love, marriage, partnership	X			
Sexual pleasure			X	
Sexual orientation	X			
Gender roles		X		
Online media and sexuality			X	
Access to safe abortion in the framework of the national law (abortion is illegal in Ireland)	N/A	N/A	N/A	N/A
Mutual consent to sexual activity		X		
Sexual abuse/violence				X
Domestic violence				X
Human rights and sexuality			X	

question, of which there are three: voluntary schools (52%), vocational schools (35%) and community/comprehensive schools (13%). Most voluntary schools are under the trusteeship of religious denominations and have retained a Christian ethos that influences their sexuality education. Vocational schools were established by the state and are therefore less dependent on religious views. Comprehensive schools were established in underdeveloped regions, and some of them are managed by religious orders.

The curriculum contains no links to information on how/where to access services.

### Teacher training

The (Ministerial) SPHE Support Service offers voluntary training to teachers delivering the SPHE curriculum. But there is no system in place

to evaluate their effectiveness and to ensure that teachers actually receive adequate support after completion of the training.

Educational materials and teaching guidelines are developed by the National Sexual Health and Crisis Pregnancy Programme within the Department of Education. They reflect a (minimal) comprehensive and participatory learning approach. The Department has produced best-practice guidelines regarding visitors to post-primary schools, stating that schools have a duty to protect pupils from 'potentially harmful, inappropriate or misguided resources, interventions or programmes'. The guidelines advise schools that programmes delivered by external agencies must use appropriate, evidence-based methodologies with clear educational outcomes and avoid disseminating information that induces fear and exaggerates negative consequences.

## Monitoring and evaluation

A number of evaluation surveys on aspects of SPHE, including RSE, have been carried out. A 2007 report on the implementation of RSE in post-primary schools observed that, where RSE is poorly developed and teachers feel uncomfortable with the subject matter of RSE, schools may develop 'an over-reliance on outside facilitators and, consequently, assign all RSE teaching to outside agencies'. Additionally, a 2013 report by the Inspectorate at the Department of Education and Skills evaluated the teaching of SPHE in 63 post-primary schools. The report was mainly positive about the implementation of SPHE, although in some cases teachers could not develop experience because of high staff turnover. With regard to senior-cycle RSE, the report found that a core teaching team had been established in 63% of schools. In the absence of such a core team, there was significant variation in the quality of RSE teaching, as it depended on the experience and expertise of individual teachers.

In 2016, Ireland was reviewed by the UN Committee on the Rights of the Child, which expressed concern about the 'severe lack of access' of adolescents to SRH education. The Committee recommended that Ireland 'adopt a comprehensive sexual and reproductive health policy for adolescents and ensure that sexual and reproductive health education is part of the mandatory school curriculum, with special attention to the prevention of pregnancy and STIs.'

### Sexuality education outside the regular school setting

The National Sexual Health Strategy states that the sexual health needs of young people in extracurricular settings should be addressed

through outreach programmes. The strategy recommends that organisations working with young people in extracurricular settings be provided with support and sexual health training to ensure they provide high-quality advice, resources and services.

The IFPA runs a programme called 'Speakeasy', which is designed to provide parents, guardians and carers with the information, skills and confidence they need to talk to their children openly about relationships, sexuality and keeping safe. Other NGOs that deliver talks or workshops on aspects of the RSE programme include local rape crisis centres, STI clinics and organisations supporting people living with HIV/AIDS. There are helpful websites aimed at young people for this purpose, notably [b4udecide.ie](http://b4udecide.ie) and [SpunOut.ie](http://SpunOut.ie) as well as state-funded websites such as [ThinkContraception.ie](http://ThinkContraception.ie) and [positiveoptions.ie](http://positiveoptions.ie), which provide information on contraception and unplanned pregnancy services, respectively. With regard to vulnerable young people, a 2016 report on the sexual health of young people in state care found that RSE, while important, 'is not considered sufficient to meet the needs of young people in care, who may have missed out on consistent, loving relationships in childhood'.

### Barriers to comprehensive sexuality education

Rather than mounting a campaign of outright opposition to sexuality education, groups opposed to the provision of information about sexuality have instead sought to influence RSE content through, for example, the production of text books and videos for use in schools which give young people incorrect information about the efficacy of contraception and the 'consequences' of engaging in sexual activity before marriage. Some groups have developed RSE workshops focusing



Ireland

on the promotion of abstinence. Such groups exercise their influence in the context of individual schools, rather than at a political or governmental level. While they do not hold an influential position with policymakers, through their school visits they do gain direct access to some groups of young people and may be perceived as a credible source of information.

Similarly, a list of supplementary RSE resources compiled by the SPHE Support Service includes a video entitled 'Sex, Love, Relationships', which 'looks at the physical, emotional and spiritual consequences of sexual activity and places an emphasis on chastity'. However, there is also evidence to suggest that young people are not necessarily susceptible to (mis)information from these sources, and engage critically with the materials presented to them, as shown by the results of a 2010 survey among young people.

### Youth-friendly SRH services

Special, separate SRH clinics for youth exist only in Dublin and Waterford; they are funded by the government. Young people usually have to pay for SRH services as well as for contraceptives. Many young people, however, do not have the

money to pay for contraceptives. The Pill costs as much as €20 per month. Most young people cannot afford sexual health services if they do not hold a government medical card. Emergency contraception is available without prescription from pharmacies. The medical age of consent is 16 years, and some pharmacists will not dispense it if girls are under this age. The age of consent for sexual relationships is 17. Condoms are for sale in many places, but supermarkets generally tag boxes and place condoms inside, which adds barriers to young people. Pharmacies sell condoms, and young people can buy them depending on the dispenser. Vending machines in pubs and clubs also dispense condoms.

### Some survey and vital data on young people's SRH

According to the ICCP-2010 survey<sup>1</sup>, 89% of the 18–25-year-olds had used contraception the first time they had sex. The HBSC Study 2014 found that, of the 15–17-year-olds who reported ever having had sex, 33% reported using birth control pills and 73% reported condom use at last intercourse.

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### Reference

1 McBride O, Morgan K, McGee H. Irish contraception and crisis pregnancy study 2010 (ICCP-2010): a survey of the general population (Crisis Pregnancy Programme Report No 24). Dublin: Health Service Executive Crisis Pregnancy Programme (CPP); 2012.

## KAZAKHSTAN

A number of laws and strategies in Kazakhstan include the right of children and adolescents to health education as well as their right to reproductive health protection. Sexuality education is currently not part of the school curriculum, but the country is successfully piloting and introducing the subject of 'valeology' which covers a number of SRH topics.





## Laws and policies on school sexuality education

The Code of the Republic of Kazakhstan on Public Health and Healthcare System dated September 18, 2009, No. 193-IV<sup>1</sup>, includes the right of children and adolescents to health education as well as the right to reproductive health protection. The ‘Strategy on Gender Equality in the Republic of Kazakhstan 2006–2016’<sup>2</sup> states the actions needed to increase youth knowledge on reproductive health, including ‘moral and sexual education’, with the aim of decreasing the number of unwanted pregnancies. However, there is presently no national policy or law that explicitly supports the introduction of school-based sexuality education.

## Organisation and implementation of sexuality education

Sexuality education is currently not part of the school curriculum, though elements thereof are included in other subjects. Topics related to HIV/STIs are discussed under the subject ‘Basics of Life Safety’ in grades 7–9 as well as during biology classes. Issues related to violence, gender relationships and creation of a family are integrated in the course ‘Knowledge of Oneself’ for pupils in grades 5–11.

## Introduction of the optional subject – ‘valeology’

More information on SRH is provided within the optional subject entitled ‘valeology’ (science of healthy living). Initially in 1996, the Kazakhstan Association on Sexual and Reproductive Health (KMPA, IPPF member association) developed a training course on valeology, which was approved by the Ministry of Education of the Republic of Kazakhstan and introduced into the school

curriculum as an optional subject. Teacher-training courses and materials were also developed. However, because of a shortage of trained teachers, opposition from parents and communities, and a weak implementation process, this subject is currently absent from the school curriculum, though it is still included as an extracurricular course in some colleges\*.

## Pilot of the new educational project on SRH

In 2012, as a part of the regional joint programme of the Government of Kazakhstan and UN agencies, UNFPA in collaboration with the East Kazakhstan Regional authorities successfully piloted an educational project on SRH for students of selected colleges in this area. The pilot project included an adaptation of the existing valeology subject with a special focus on SRH issues in line with the UNESCO standards<sup>3</sup>. College teachers from pilot areas were trained on the subject using specially designed teaching materials, and they then taught the classes according to the developed teaching curriculum. The course was delivered to 4 000 pupils in three regions (oblasts).

## Evaluation of the pilot and next steps

A study conducted to assess the level of pupils’ knowledge before and after attending classes in valeology proved its effectiveness. Awareness of HIV-related issues increased from 5 % to 16.5 %. Insight into the need to use condoms during sexual intercourse increased from 6.8 % to 16.2 %, and the level of awareness of the symptoms and the need for treatment of STIs increased from 34.3 % to 51.2 %. The study also confirmed that the moral and sexuality education did not cause an early onset of sexual activity among adolescents.

\* Secondary professional education

Accumulated successful experience of teaching pupils on issues related to SRH was presented at national conferences in 2014 and 2015. In 2015, the participants of the conference, representing the Parliament of Kazakhstan, the Ministries of Health and Social Development, Education and Science, Culture and Sports, approved a resolution with recommendations to ensure education on SRH for adolescents and youth. In particular, at this stage the advice was to extend the successful experience of teaching college students in the East Kazakhstan Region to all colleges of the country. At a national meeting held in June 2016, it was agreed to introduce the subject of valeology into the mandatory curriculum of professional and technical educational institutions in Kazakhstan. During the period of 2017–2020, the Ministry of Education, in collaboration with other partners, plans to work on introducing valeology into the school curriculum.

### **Opposition to sexuality education**

Despite the progress, there is still opposition to sexuality education from teachers, parents, religious leaders and some politicians. The main argument is the presumed resulting increased interest in sex on the part of youth.

### **Sexuality education outside the formal school setting**

Sexuality education is provided through the Y-PEER network for youth, which is expanding in Kazakhstan. The Y-PEER Kazakhstan network was launched in 2007, and its main aim is to strengthen and spread high-quality peer-to-peer education in the field of SRH and HIV prevention.

### **Youth-friendly SRH services**

There are around 80 youth-friendly health centres, mostly concentrated in the big cities, which provide young people with medico-psychological, legal and social support. These are also governmental services, established with the support of UNFPA, that provide free services to youth.

Emergency contraception has to be prescribed, though it is often available in pharmacies without a prescription. Contraceptives are not provided for free, and the price can often be a barrier for young people. The practice has arisen of buying contraceptives with local budgets for vulnerable groups of youth, but this depends on the directors of medical centres and their skills to calculate contraceptive needs. The age of consent for contraception is 16 and for abortion is 18 years. However, in order to access SRH services, adolescents under 18 require parental permission.



## Survey and vital data on young people's SRH

According to a study<sup>4</sup> performed in 2011, preferred sources of information by youth were mainly:

Sources of information which are preferred by youth	
Parents	34.4 %
School/teachers	49.7 %
Radio/TV	60.3 %
Internet/social networks	43.3 %
Healthcare workers	45.8 %

According to UNICEF MICS 2010-2011<sup>5</sup>, 19.2 % of 15–19-year-old women who were married or in a relationship used modern contraceptive methods. According to the Dermatology and Venerology Research Institute under the auspices of the Ministry of Health and Social Development, in 2014–2015 approximately 26 % of 15–17-year-olds were sexually active, and 38.4 % had been diagnosed with STIs.

## References

1 Available at [http://adilet.zan.kz/eng/docs/K090000193\\_](http://adilet.zan.kz/eng/docs/K090000193_)

2 Available at [http://www.akorda.kz/upload/nac\\_komissiya\\_po\\_delam\\_zhenshin/5.2%20%D0%A1%D0%93%D0%A0%20%D0%B0%D0%BD%D0%B3%D0%BB.pdf](http://www.akorda.kz/upload/nac_komissiya_po_delam_zhenshin/5.2%20%D0%A1%D0%93%D0%A0%20%D0%B0%D0%BD%D0%B3%D0%BB.pdf)

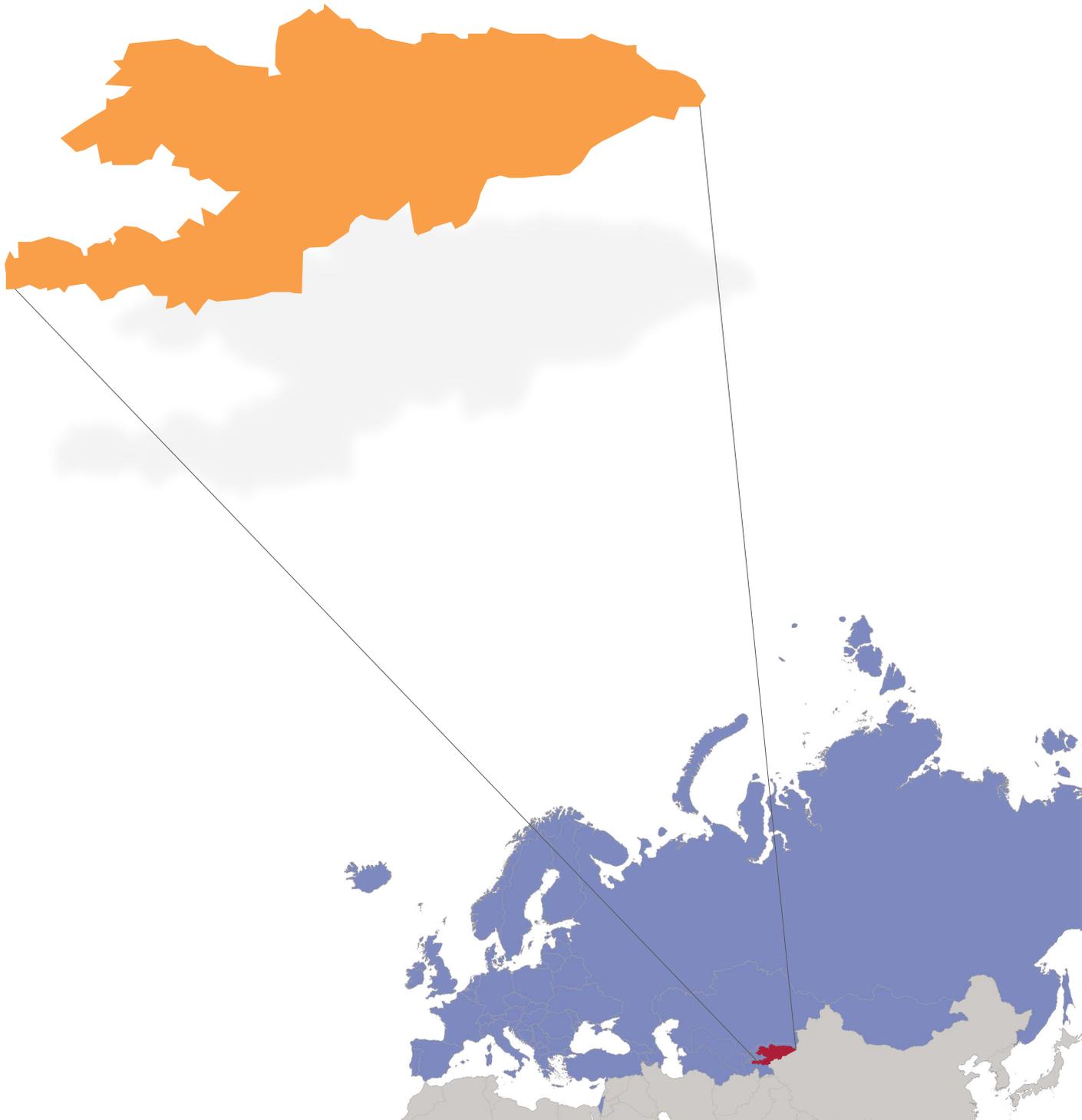
3 UNESCO (2009). International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators. Paris: UNESCO.

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## KYRGYZSTAN

In close collaboration with international donors, the government has taken a number of steps to integrate sexuality education into the school curriculum. Currently, sexuality education in Kyrgyzstan is not a stand-alone subject and its delivery varies across the country.





## Laws and policies on school sexuality education

A number of laws regulate reproductive rights and access to education on it. Among them are the 'Law on Reproductive Rights of the Citizens and Guaranties of their Fulfilment' (2015)<sup>1</sup>, the 'Law on Principle of State Youth Policy' (2009)<sup>2</sup> and the 'Law on Education' (2003)<sup>3</sup>. In 2015, a number of changes were made to the 'Law on Reproductive Rights of the Citizens and Guaranties of their Fulfilment', including granting access to information about SRH. This law covers almost all reproductive rights matters, though sexual rights are not broadly stated.

## Organisation and implementation of sexuality education

### Responsibilities

The institutions that are mainly responsible for the curriculum development are the Ministry of Education, the Kyrgyz Academy of Education and the parent committees of the respective schools.

### Sexuality education in practice

Since 2015, sexuality education has been integrated in the subject 'Healthy Lifestyle' for pupils of grades 6–11 (12 years and older). Pupils in each grade are supposed to be taught 10 hours on this subject per year. It includes a number of topics:

- Me and my health
- Human hygiene
- Communication 'ABCs'

- Violence and how to protect yourself from violence
- STI prevention
- Prevention of brucellosis
- Adolescence
- Bodily hygiene during adolescence
- Sexual development and gender
- Sexual health of adolescents
- Sexual relationships
- HIV prevention
- Responsible behaviour
- Reproductive health and rights
- Family planning
- Teenage pregnancy: responsibility and choice
- Early marriages and bride kidnapping
- Tolerant attitudes
- Talking about suicide
- Use of psychoactive substances

The above-mentioned topics are spread over different grades. For the pupils of grades 6–7, most topics are related to healthy eating and hygiene, HIV and psychoactive substance use. Starting from 8th grade, topics related to SRH such as reproductive rights, gender equality and

sexuality are included. Information on where to receive SRH services is not included.

Healthy Lifestyle is not a mandatory subject, and the teachers decide whether to include it as a lesson. The subject is delivered differently, for example, depending on the level of preparedness of teachers, the level of religiosity in the region where the school is located, the presence of suitable materials for teachers, the willingness of the school administration to include it in the curriculum and numerous other factors (e.g. financial, i.e. payment of teachers). A simple lack of teachers can affect the possibility of teaching a class because of the additional workload. Because of this high workload and the lack of training for teachers, many NGOs carry out various educational sessions and workshops on SRHR for different age groups using an interactive format. They also provide classes during World AIDS Day, World Health Day, etc.

### Teacher training

In 2014, the Ministries of Education and Health, and the Kyrgyz Academy of Education approved methodological guidelines for teachers on the subject of Healthy Lifestyle, which were then developed together with UNFPA and GIZ. But no special nationwide training is provided for the teachers.

### Opposition to sexuality education

There is opposition to sexuality education in the country. The following is an illustration.

In 2013, a scandal occurred because of the distribution of brochures on sexuality education among the country's schoolchildren. The development of these booklets had been initiated in 2002 by experts from several international

and national NGOs: UNICEF, GIZ, and the Reproductive Health Alliance Kyrgyzstan (RHAK; IPPF member association)\*. They conducted a study on these issues among youth and adolescents in Central Asia, including Kyrgyzstan. The study found that adolescents need high-quality and reliable information in the field of puberty, prevention of infections and unwanted pregnancy. Specialists and volunteers from RHAK, including medical professionals, psychologists and educators became involved in the design of these brochures.

Some public figures, however, saw the brochures as 'sex propaganda'. This scandal raised a very important question: How to organise sexuality education for young people in Kyrgyzstan? Opposition to sexuality education was supported by the Parliament of the Kyrgyz Republic, leading to a meeting of the Education Committee. Among the opponents of the dissemination of these brochures on sexuality education were the Russian Orthodox Church, the Spiritual Administration of Muslims of Kyrgyzstan, an analytical centre 'Religion, Law and Politics', as well as some political parties. They noted that 'the content of these brochures undermines the morals of our youth, the foundations of family relationships, and in the long term, it poses a threat to the gene pool of the nation'.

In response to this opposition, representatives of the medical and educational fields, youth and NGOs stated their opinions. They were joined by representatives of political parties and government bodies. A public discussion began which finally resulted in the development of a number of methodological guidelines.

\* <http://www.rhak.kg/>



## Sexuality education outside the formal school setting

Extracurricular sexuality education is provided by NGOs, e.g. RHAK through different programmes such as Y-PEER. Information on sexuality education is also provided via local TV/radio channels and internet sites, where topics such as sexuality, pregnancy, abortion, and contraception are widely discussed.

### Good practices

1. A *'training trainers'* project among youth and adolescents is based on the 'peer-to-peer' principle, which covers almost all regions of the country and has a long history since 2001. It was successfully promoted by several NGOs and provides coverage of youth from different groups in non-formal educational settings.
2. 'Promotion of Comprehensive Sexuality Education in the System of Vocational Education in Kyrgyzstan', implemented by RHAK with the support of IPPF. In 2015, RHAK worked closely with the Agency for Vocational Education (АПТО) to introduce sexuality-education programmes for pupils in three pilot regions. The aim of the project was to form stable connections in the vocational education system between formal and non-formal education on SRHR and to establish a referral system for providing pupils with youth-friendly consultations. The result of this project was a jointly developed plan to increase the capacity of schoolteachers to deliver the subject of Healthy Lifestyles and to train peer educators among pupils in the Talas, Issyk-Kul and Chui regions (oblasts).

## Challenges and recommendations

1. SRH youth policy: There is a need for strong political and financial tools to implement existing legislation to ensure that sexuality education is standardised and implemented. In order to achieve this,
  - the government should instruct the relevant ministries and agencies to develop recommendations to improve/create a regulatory-legal framework to ensure young people's access to integrated and comprehensive education in the field of SRH;
  - a budget should be allocated to pay teachers' salaries and to provide appropriate training;
  - the introduction of sexuality education should be subjected to M&E. It is also necessary to develop simple and affordable assessment tools.
2. Prioritise the health of young people in the governmental agenda and ensure that all young people, including especially those most at risk, have access to SRH services. The current healthcare system does not provide services that reflect the needs of young people, including the field of SRH. Partnerships with NGOs as service providers could facilitate access for all young people to SRH services.
3. Youth participation:
  - Give young people the opportunity to participate in the development of relevant programmes and policies and also to influence the developmental processes. Their involvement would help to ensure compliance with policies and SRHR programmes reflecting their real needs.

- Involve NGOs and community groups in the development of such documents and their implementation at the local level.
- Discuss more complex issues related to youth in the context of different demographic dynamics in different regions of the country.
- Create employment opportunities that would allow use of the productive potential of young people, and promote solidarity between generations.

All of these would facilitate the development of the main directions of long-term strategic development, taking demographic characteristics of the country, with its significant proportion of young people, into account.

### Youth-friendly SRH services

In 2012, ten youth-friendly clinics were established as part of a RHAK project where all services were provided for free. After the end of this project, during the last 2–3 years, all of these clinics almost ceased operating because of a lack of financial support from the Ministry of Health. They were financed by NGOs and international donor agencies, but not integrated into other medical facilities.

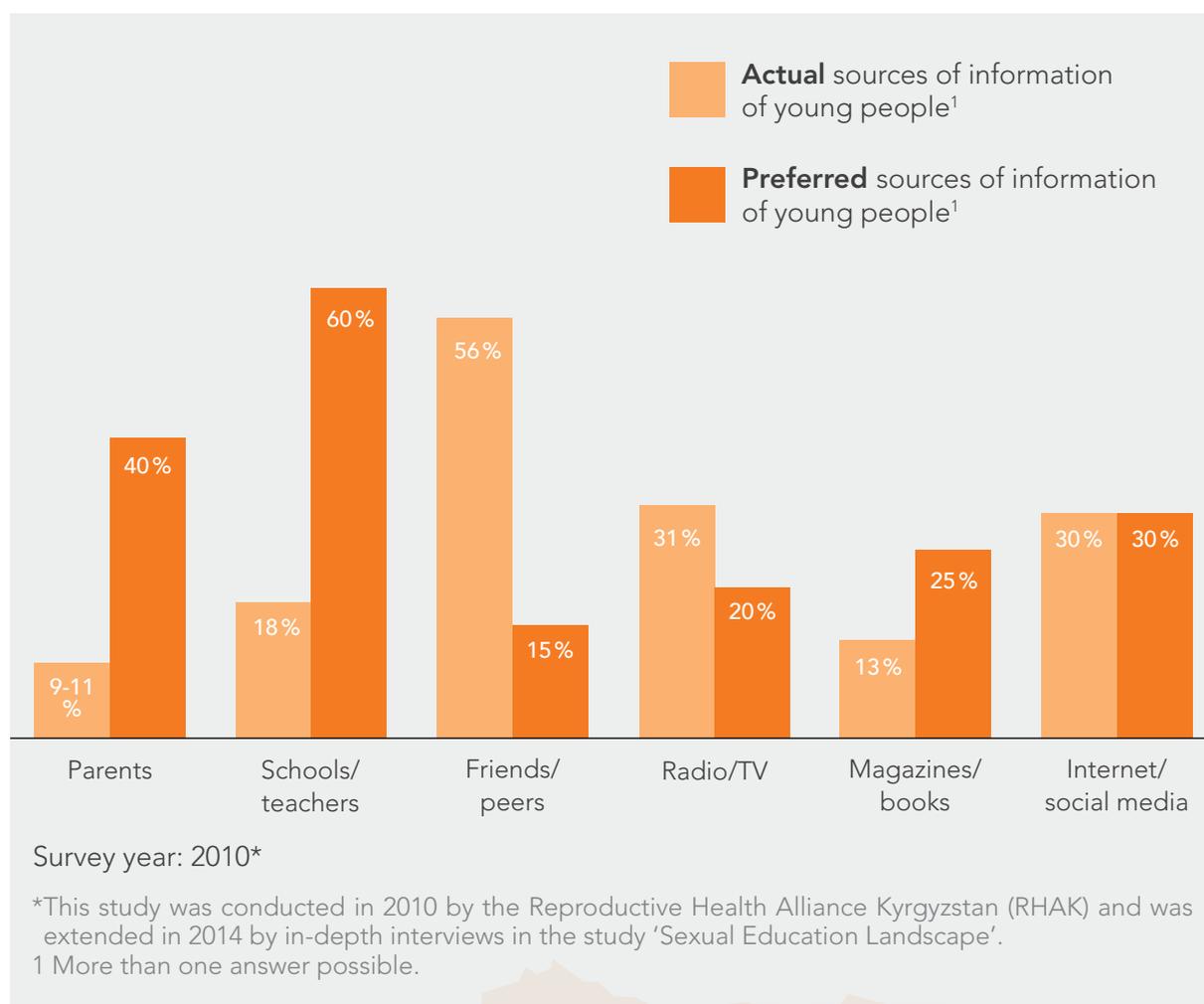
Young people in Kyrgyzstan have to pay for SRH services including STI testing and treatment, gynaecological services, antenatal care and abortion. This is a significant barrier for most young people. Emergency contraception is available from pharmacies and young people can buy condoms in public places, supermarkets and pharmacies. They have to pay for all types of contraception, which is also a significant barrier. There is no defined age of consent for contraception, but for abortion it is 16 years.

### Survey and vital data on young people's SRH

According to the Ministry of Health, in 2015, 1 408 girls under 20 had an abortion. In 2015 there were 297 registered STI cases among 15–19-year-olds.



### Actual and preferred sources of information for young people, on sexuality-related issues



#### References

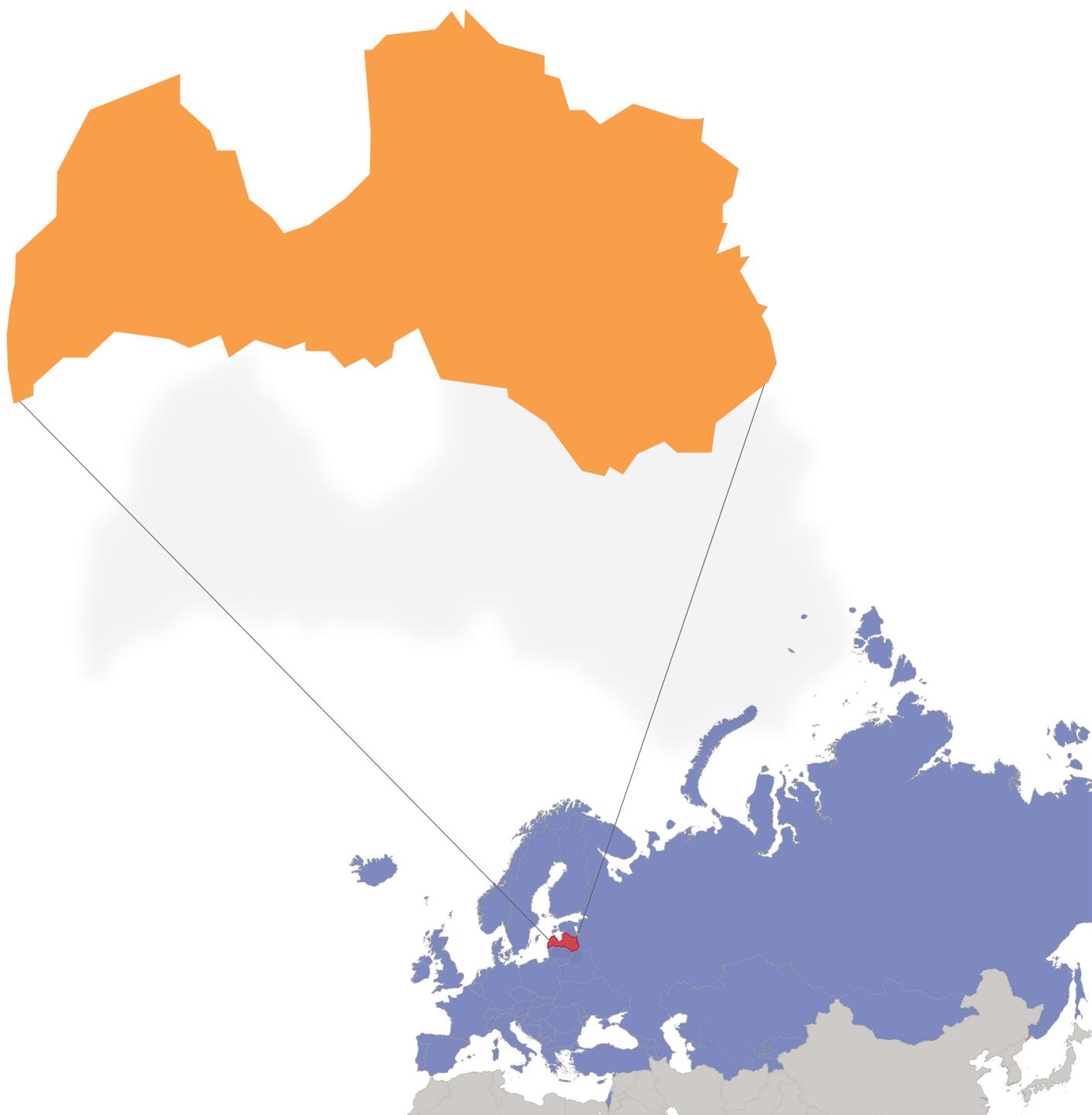
1 Available at <http://cbd.minjust.gov.kg/act/view/ru-ru/111191>

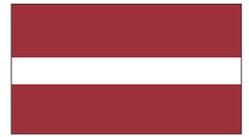
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## LATVIA

In Latvia, there is no specific law, policy or strategy concerning sexuality education, nor is there a national curriculum. Instead, seven different governmental regulations or guidelines provide opportunities for sexuality education that can, but need not necessarily, be used. Because there is a fair degree of municipal and school autonomy in this respect, it is assumed that there is wide variation in practice. There is also considerable opposition to sexuality education in Latvia.





## Laws and policies on school sexuality education

Seven different governmental regulations and guidelines provide the legal framework for sexuality education in Latvia, all of which are concerned with education in general and not specifically with sexuality education. For example, there are the Educational Development Guidelines 2014–2020, issued by the national parliament in 2014, and the Regulations on the National Standards of Upper Secondary School Subjects and Model Syllabi (2013), issued by the Cabinet of Ministers (2013). The latter one includes ‘Health Studies’, a subject standard for grades 10–12. The goals of these regulations and guidelines are to define the overall standards, tasks, goals and methods of each teaching subject. One of the sub-goals of the Guidelines is ‘to promote the development of the individual’s professional and social skills (including “civic co-responsibility and social activity”) based on values of education for life (...)’ Development of ‘healthy lifestyles’ is explicitly mentioned in these guidelines which can be interpreted as supporting sexuality education, but this depends on how schools implement the defined goals and tasks. There is no identifiable national curriculum for sexuality education, though elements thereof may be included in various teaching subjects, including social studies, biology, health studies, natural sciences and ethics.

As far as health promotion is concerned, local governments can develop their own health-promotion strategy (based on state-designed public health guidelines for municipalities). All municipalities have developed their own public health strategies in which sexuality issues may be included. This may seem comprehensive, but it can also be focused more on abstinence, while still including prevention of pregnancy and STIs/HIV.

Several municipalities provide sexuality education via peer-education classes.

The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) have been translated into Latvian, and teachers have been introduced to it, but because no state M&E mechanisms exist for sexuality education, no information is available whether (or how) the *Standards* are being used by teachers.

Because sexuality education is (or should be) integrated into other subjects, it automatically becomes mandatory. The number of teaching hours devoted to sexuality education, however, differs from school to school. The law does not define a particular number of teaching hours for it; rather, the teacher is free to choose ideas for discussion and activities that he or she feels to be most suitable for each class, or the teacher does so together with pupils. For 12–15-year-olds, the maximum number of hours in which sexuality education can be included is 27, and for the over-16s this is about 5 hours.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education and Science and the related National Centre for Education are responsible for curriculum development. Educational and health professionals are invited to participate in technical expert groups that review the curriculum. Subject standards are published, and in principle everyone has the opportunity to react to them. Religious groups and NGOs are sometimes invited to participate in curriculum-development working groups at the municipal level. Parents can also become members of the advisory

boards of schools attended by their children, and as such they can influence educational programmes. After amendments to the education law (called the ‘morality amendments’), which state that schools must protect pupils from information and methods that could potentially harm their morals, parents have some say in defining what methods or information used in sexuality education are deemed ‘dangerous’ through the Parents’ Council of a particular school. The regulation for this council (and other councils) states, among other things, that the council ‘shall participate in discussing the educational process and its results and provide proposals for improving the quality of education in the educational institution’.

## Sexuality education in practice

The table (filled in by both respondents, i.e. a representative of the Ministry of Education and of the IPPF member association, ‘Papardes zieds’) indicates that sexuality education does not tend to be comprehensive. Except for biological aspects, all other subjects are usually dealt with only briefly.

Teaching materials and guidelines are developed by three bodies:

1. The National Centre for Education, which provides methodical materials for teachers in secondary and vocational schools for the subjects Health Studies and Social Studies.

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth		X	
Contraception (including at least three effective methods)		X	
HIV/AIDS		X	
STIs		X	
Love, marriage, partnership		X	
Sexual pleasure			X
Sexual orientation		X	
Gender roles		X	
Online media and sexuality			X
Access to safe abortion in the framework of the national law			X
Mutual consent to sexual activity			X
Sexual abuse/violence			X
Domestic violence		X	
Human rights and sexuality		X	



2. The Centre for Disease Prevention and Control, which developed educational videos (on 'Boys, Girls and Puberty' and on 'Relationships and Health') and provides methodological recommendations for general and vocational education teachers for working with pupils on reproductive health, sexual and relationship issues. Brochures for pupils are also available.
3. The IPPF member association Papardes zieds provides online materials developed by the Ministry of Education on different health issues, including sexual topics. These materials are generally comprehensive and apply participatory approaches. Papardes zieds also gives sexuality-education lessons in schools, and it has a video film for girls and parents about sexuality education. Furthermore, there is a wide range of videos related to sexuality education which are all available online. For example, episode 3 of the video 'Boys, Girls and Puberty' is called 'We Are Unique, Each of Us'. There are no direct links with SRH service provision. Pupils are informed that, in order to get information on SRH services, they must consult with their own doctor, as is outlined in the Sexual and Reproductive Health Law<sup>1</sup>.

### Teacher training

Only a few teachers have been trained specifically to teach sexuality education. Teachers' participation in training programmes depends on how many credit points they have to get in their particular study programme.

### Monitoring and evaluation

There have been evaluations of teaching subjects in which sexuality education could have been included. For example, in 2013 the National Centre for Education did 'diagnostic tests' on the

subject of 'Social Studies,' grades 5 and 9. Two other evaluations were carried out as well, one by the same centre and the other by Papardes zieds. The results of the latter evaluation showed that the quality of the delivery of sexuality education (by Papardes zieds!) has steadily increased. Usually the average score of quality evaluation from teachers and pupils is around 8 on a 10-point scale.

### Sexuality education outside the regular school setting

Papardes zieds organises special lessons and activities for teaching children out of school on sexual (health) topics. It also provides information and an option to ask questions and get answers on its website. Church organisations provide abstinence-only and family-value education at schools and in their own centres.

### Vulnerable groups and special services

Papardes zieds developed sexuality-education training for the teachers and people working with young people living with intellectual disabilities. It has also developed a sexuality-education programme for young people in correctional institutions. However, it is unknown whether these programmes are still being implemented. An organisation named 'Dia&Logs' provides support to and organises prevention education for HIV-positive people and their peers.

### Good practices and initiatives

When asked about examples of good practice, respondents mention the Swedish 'Bella – programme' (also implemented in Latvia), developed for girls to strengthen their self-confidence and decision-making skills related to healthy lifestyles (including sexuality, drug and alcohol abuse).

## Opposition to sexuality education

Conservative and nationalist political powers like the National Union ('Nacionālā Apvienība'), Russian-speaking groups, the opposition party Harmony ('Saskaņa'), and conservative family-based NGOs oppose sexuality education. Their main arguments are that it endangers the demographic situation, that sexuality education teaches children to masturbate and have underage sex, and that this information damages children's morality, endangers the 'right' and 'healthy' concept of the family, and that it 'turns children into homosexuals'. For that reason, Papardes zieds recommends that legislators drop the 'morality amendments' from the education law, and that sexuality education be fully integrated into the school education systems as recommended by both the WHO and BZgA *Standards for Sexuality Education in Europe* (2010) and the UNESCO guidelines<sup>2</sup>.

## Youth-friendly SRH services

There are no special youth-friendly SRH service centres or clinics in Latvia, and young people usually must pay for (adult) SRH services. Some STI testing is free of charge, but chlamydia testing and treatment must be paid for. Gynaecological care is free of charge if provided by a general practitioner. Some services from gynaecologists may also be free of charge (if the state agreement covers it), but there are waiting lists for such specialists, so access is limited. Healthcare in general is free of charge for children up to age 18, including testing, treatment and counselling. Young people over this age, however, must pay a patient fee. HIV, hepatitis B and C and syphilis rapid testing and counselling are available free of charge for everyone at the HIV prevention centres. Young people must pay for all contraceptive supplies, including emergency contraception,

which is available without prescription from pharmacies without any age restriction. Condoms can be bought in supermarkets, kiosks, etc. Still, the cost of condoms can be a real barrier. A pack of 3 condoms costs around €2.50 (the minimum monthly wage after taxes being only €370). Young people usually receive the minimum wage or work only part time, so that the cost of condoms is quite high for their income.

Abortion is legal and available on request within the first 12 weeks of pregnancy (but not free of charge); for medical reasons it is allowed up to 22 weeks. The age of consent for abortion and for contraception is 16 years. Young people under the age of 16 can receive contraceptive and abortion services if at least one of their parents or guardians has given written approval.



Latvia

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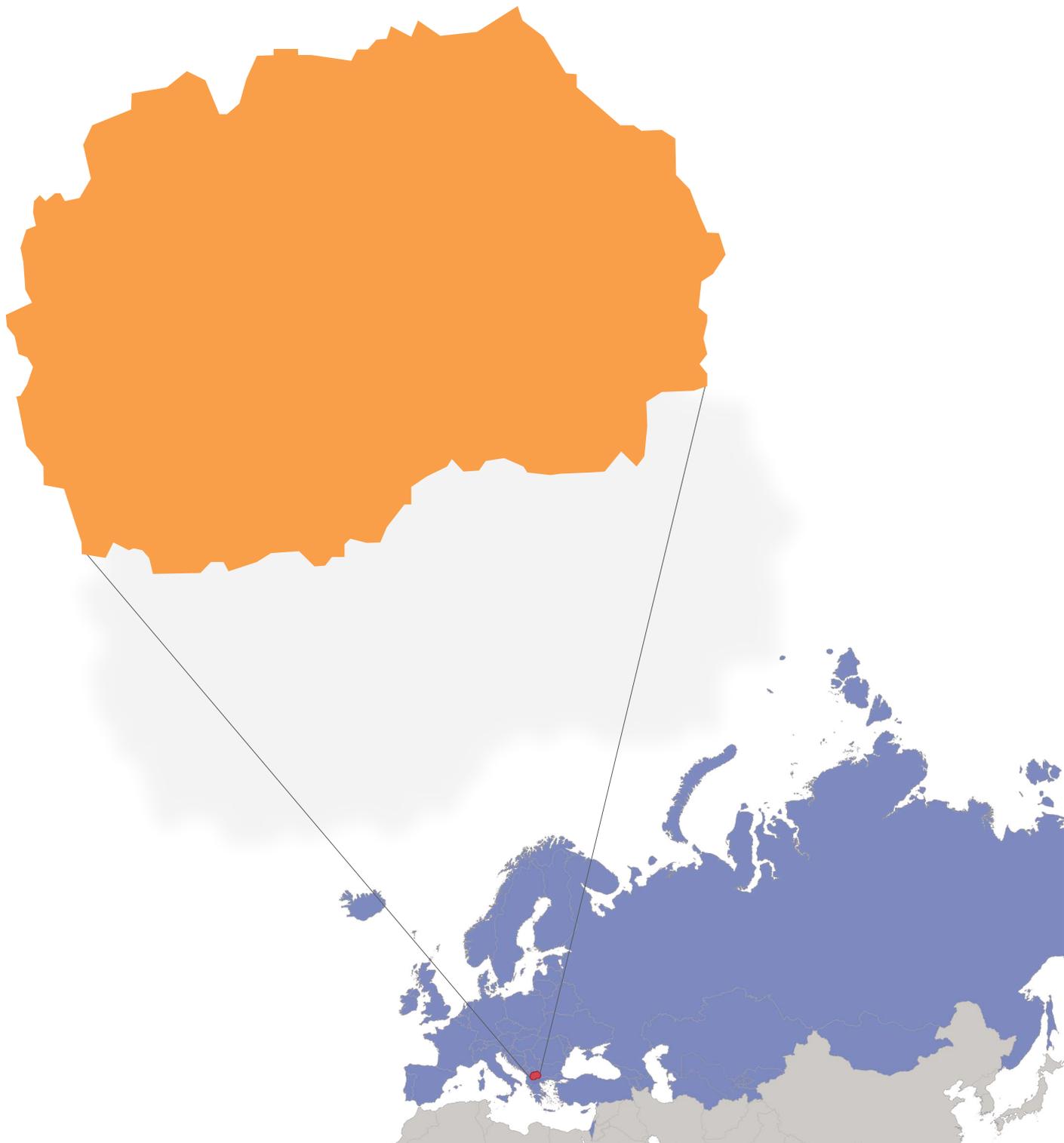
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2 UNESCO (2009). International Technical Guidance on Sexuality Education. An evidence-informed approach for schools, teachers and health educators. Paris: UNESCO.

## THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Three national strategies relate to sexuality education, but to date it has not become a teaching subject. In 2011, a 'Framework for Comprehensive Sexuality Education' was adopted, but this has not led to any subsequent related action plan. Research has shown that schools are hardly a source of information on SRH. There is a lack of governmental support for sexuality education.





Macedonia (fYRoM)

## Laws and policies on school sexuality education

There are three national strategies in the fYR of Macedonia, that are (partly) related to sexuality education:

The ‘National Strategy for Youth’ (2015–2025) includes the objectives:

1. ‘to ensure appropriate coverage of sexuality education themes in the formal and non-formal education’;
2. ‘to reduce risky behaviour and violence (related to SRH, tobacco, alcohol and drugs) among youth 15–25’; and
3. ‘to ensure equal access of all young people to health’.

The ‘National Strategy for HIV’ (2012–2016) aims ‘to maintain the low HIV prevalence in Macedonia through providing universal access to prevention, therapy, care and support based on human rights and non-discrimination’.

The ‘National Strategy for Sexual and Reproductive Health’ (2010–2015) aims ‘to improve the SRH of all citizens of Macedonia till 2020’.

These three strategies support improving SRH education. Strategies 2 and 3 use the term ‘sexuality education’, while strategy 1 refers to ‘comprehensive sexuality education’. There are also several educational sub-objectives within different subjects which address STI/HIV prevention, condom use, relationships, sexual orientation, non-discrimination and sexual abuse. There are many challenges to implementing the strategies. For example, the National Strategy for Sexual and Reproductive Health was adopted without

a related action plan because the government could not accept the measure of providing oral contraception.

## Organisation and implementation of sexuality education

### Responsibilities

There is no separate school subject entitled sexuality education in the fYR of Macedonia. Some elements thereof are included in various other subjects. For example, STIs are covered in Biology (primary school) and in Life Skills Education (LSE; primary and high school). Also, some information is included in Sociology and Citizenship Education (high school). All subjects that have educational objectives related to sexuality education are mandatory, like Biology and LSE. Although LSE is a mandatory subject, it is implemented only during weekly ‘living room’ or ‘advisory classroom’ sessions (not part of the regular teaching curriculum). Also, teachers decide for themselves which components to include during the year.

The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) were used to some extent, in particular for the advocacy process with different stakeholders, mainly with MPs who refer to the document. This advocacy process was initiated by civil society organisations, and the most significant achievement was the development of a ‘Framework for Comprehensive Sexuality Education’. The consultative process was under the guidance of Prof. Roger Ingham (University of Southampton, UK), which involved the responsible Ministries, the University, UN offices and NGOs. This framework was adopted in 2011 by the Parliamentary Commission on Equal Opportunities and the same commission recommended piloting sexuality education in schools.

## Sexuality education in practice

LSE starts in the first grade of primary school (6 years old) and runs through the end of high school (18 years), but the main educational sub-objectives that might be considered sexuality education are set for pupils 12 years of age and older. LSE fills 36 teaching hours annually for all themes of the subject, but it is not possible to assess the number of hours actually spent on sexuality education.

The LSE programme development was initiated and financially supported by the Macedonian office of UNICEF in Skopje. Educational professionals and the NGO 'CHRRCR' (Centre for Human Rights and Conflict Resolution) were also involved in this.

The table provides an impression of what sexuality education topics are most likely being addressed.

The overview refers to those subjects that have some objectives related to sexuality education, not to what is actually being taught. For example, biological aspects are covered extensively, but the information in the textbooks is not related to human sexual behaviour.

## Teacher training

Few teachers have been trained specifically to teach LSE. Training courses on LSE teaching are available, after which participating teachers are obliged to teach their fellow teachers on the course content. However, sexuality education-related

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth		X	
Contraception (including at least three effective methods)		X	
HIV/AIDS	X		
STIs		X	
Love, marriage, partnership		X	
Sexual pleasure			X
Sexual orientation		X	
Gender roles		X	
Online media and sexuality			X
Access to safe abortion in the framework of the national law			X
Mutual consent to sexual activity	X		
Sexual abuse/violence		X	
Domestic violence		X	
Human rights and sexuality		X	



Macedonia (fYRoM)

subjects are rarely part of this training. Educational materials are developed by the governmental Bureau for the Development of Education. The materials do not reflect a comprehensive approach to sexuality education. Teachers receive guidelines on how to conduct workshops with their colleagues. Most of the workshops are based on a participatory methodology. The guidelines are available in both Macedonian and Albanian. In a needs assessment conducted in 2014 by 'HERA' (IPPF member association), more than 50% of the teachers responsible for LSE stated that they needed additional time, guidelines, skills and training in order to teach SRH-related themes. One year earlier, HERA, the Bureau for Development of Education and the Ministry of Education and Science agreed to develop such additional guidelines for teachers responsible for LSE on SRH themes. The extent to which sexuality education is taught varies across the country. Since teachers themselves can select the components of LSE, most of them choose to avoid themes they are not comfortable with, i.e. those related to SRH. For example, only 7% of teachers from the capital city stated that they had talked about sexual orientation in LSE classes, 9% addressed oral contraception, 15% condom use and 35% HIV prevention.<sup>1</sup>

The parents of pupils are not involved in LSE. Information on SRH services for youth is not included in the mandatory teaching subjects.

### Monitoring and evaluation

LSE is not part of the M&E system of the State Educational Inspectorate.

### Sexuality education outside the regular school setting

Information on SRH services for young people is shared only in non-formal sexuality education classes provided by NGOs, which includes comprehensive non-formal sexuality education provided by peers. A curriculum was developed by HERA, based on the recommendations of the 'Inside and Out' tool (created by IPPF in partnership with UNESCO<sup>2</sup>). It is participatory, has an M&E system in place, and it was developed by young people and educational professionals in workshops on gender, SRH, relationships, diversity, violence, pleasure and sexual citizenship. But NGOs are facing challenges when they try to enter schools because there is no approval by the Ministry of Education and Science. HERA also organises workshops on SRH issues, including the topics just mentioned, in their own youth-friendly service centres. The Red Cross is active in peer education on HIV prevention, and Public Health Centres give lectures on it. Furthermore, there is a 'Sexy Hood' radio show on various sexuality issues.

There are various educational activities that target vulnerable and high-risk groups. HERA, through their youth-friendly centres and peer education, provides education for Roma, LGBT, sex-workers, and drug users as well as, along with UNFPA, for migrant young people. The State Institute for Social Affairs and HERA developed and is implementing an SRH educational programme for people with disabilities through its network of day-care centres. The NGO 'EGAL' works on HIV prevention and SRH for MSM, and the NGO 'Stronger Together' deals with prevention among HIV-positive people. The 'Coalition for Sexual and Health Rights' of marginalised communities provides education on sexual rights for LGBT and transgender people. Finally, the NGO 'HOPS' works with drug users and sex-workers.

## Opposition to Sexuality Education

There was recently a backlash on women rights (i.e. new restrictive abortion law), gender equality, LGBTI rights and vulnerable groups, all of which have been under attack by extensive media campaigns. While the consultation process among state institutions and NGOs was advancing towards improving Life Skills Education, in 2013 the Minister of Education and Science stated he would 'not allow curricula in which same sex relations are presented as equal to those between men and women', although no proposals existed with this message. This had a huge impact on schools (directors are appointed by ministries), which then tabooed sexuality education and closed the doors to NGOs to provide non-formal education. Most of the media supported the Minister's statement with articles on how sexuality education 'promotes homosexuality', and that it runs against traditional Macedonian values.

## Challenges

HERA feels that there is a need for improving the LSE curricula by including educational objectives and information on all sexuality-education components. Furthermore, support for teachers, additional training and provision of clear guidelines and a safe atmosphere are essential. The Ministry should guarantee that the complete curriculum is implemented by introducing a proper M&E system. Finally, the Ministry should take measures to ensure the participation of young people in developing the curricula. In the long term, there is a need for establishing a multidisciplinary body (with academia, professionals, young people, NGOs and parents) that will work on defining a systematic and suitable model for sexuality education in the FYR of Macedonia.

## Youth-friendly SRH services

There are two stand-alone youth-friendly SRH centres in the capital city of Skopje which provide integrated SRH and HIV services free of charge, including gynaecological exams, HIV and STI testing, psychosocial support, legal aid, SRH education, condom and oral contraceptive distribution. They are run by NGOs in partnership with the Public Health Institution – Skopje (under the Ministry of Health). One of them ceased operations in June 2017, when international funding stopped.

In all other settings, young people have to pay for most SRH services, including STI and HIV testing and treatment, gynaecological and prenatal care as well as abortion. The cost of these services represents a serious barrier for many young people. Though healthcare is covered by the state, the client must pay a minimal fee for each service. Gynaecological and prenatal services are supposed to be free of charge, but there is strong evidence that there are gynaecologists who in fact charge for these services. Most of the specific SRH services used are from the private health sector, for reasons of quality and confidence. Financial hardship is also a problem because of the high unemployment rate of 24 %; 48 % of the unemployed in the FYR of Macedonia are young people.

Emergency contraception is only available on prescription. Through the Global Fund on AIDS, Malaria and TB programme, the FYR of Macedonia was procuring condoms free of charge, which were then distributed through NGOs to vulnerable populations. Condoms are widely available through kiosks, drugstores, supermarkets and petrol stations. However, they are not affordable for many young people, because the price of €1–2 for a package of 3 is too high for them. All other contraceptives also must be purchased,



Macedonia (fYRoM)

and several methods are not available (such as vaginal ring, contraceptive patch, injectables and implants). The price of the most affordable type of oral contraception (not included in the health insurance) is prohibitive for the 40% lowest income segment of the population<sup>3</sup>.

The Law on Health Protection states that people under 18 years of age can access health services only when accompanied by their parents, but in everyday practice medical providers do prescribe oral contraceptives to minors. The age of consent for abortion is 18 years.

### Some survey and vital data on young people's SRH

According to Vasilevska (2014), parents (56.3%), internet and social media (53.9%) as well as peers and friends (38.5%) are the most important sources of information on sexuality-related issues. The school (1.8%) plays a negligible role. The Multiple Indicator Cluster Survey (2011<sup>4</sup>) indicated that contraceptive use among young people up to 25 years of age is extremely low: oral contraceptive use is practically nil; slightly more than 1% use an injectable; and fewer than 6% use condoms. However, the 2016 HBSC study found much higher percentages among 15-year-old girls: 48% use condoms and 15% use the pill.

The reasons for these discrepancies are unknown. The HIV infection rate among 15–24-year-olds is extremely low at 8 documented cases in the entire population.

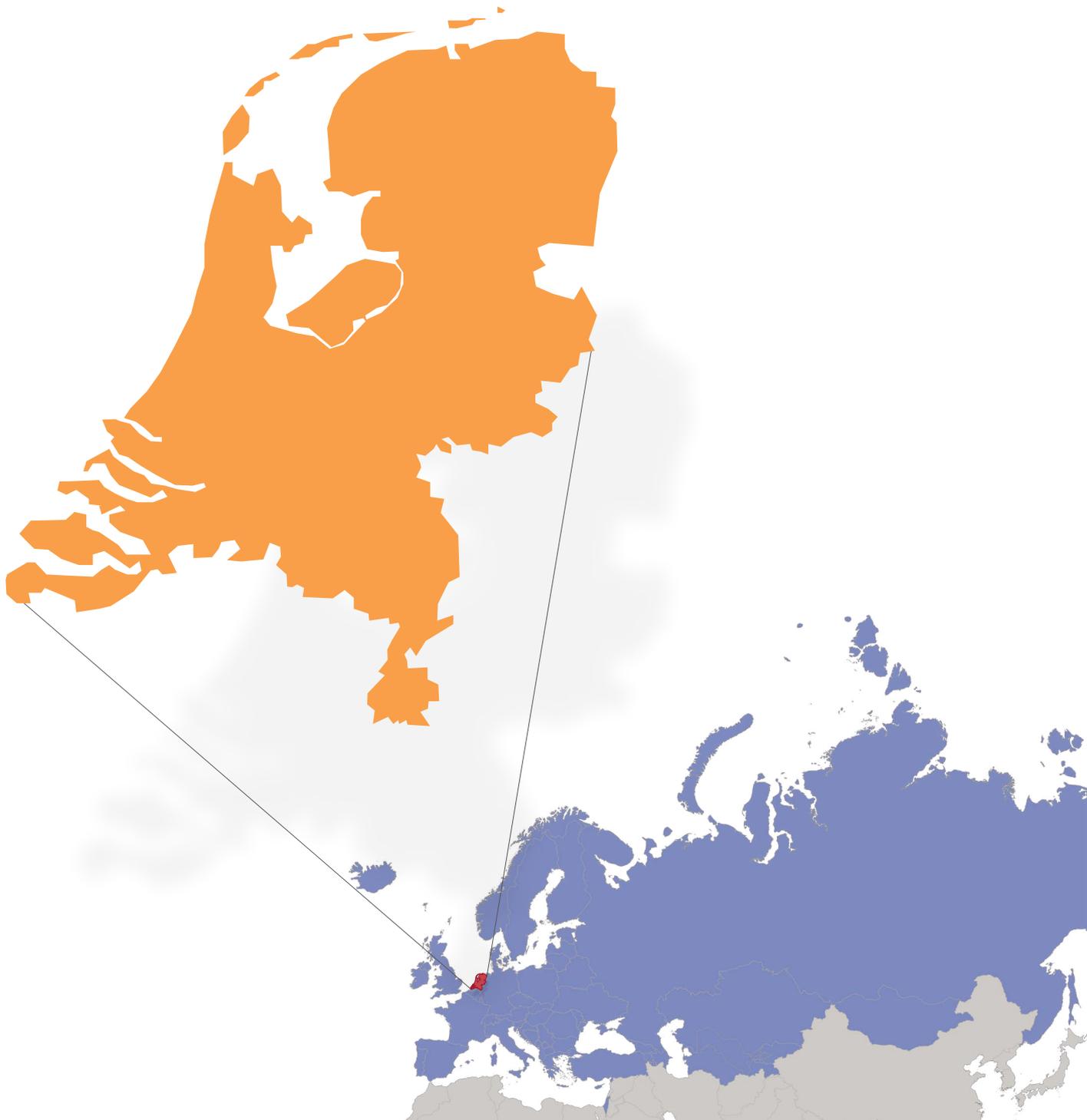
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## THE NETHERLANDS

Although sexuality education was already being delivered in almost all schools, only in 2012 did the subject obtain a legal basis. Sexuality education is presently not a separate teaching subject, nor is there a national curriculum for it. Rather, schools are free to choose their way of delivering sexuality education. In practice, it is comprehensive in character. The Inspectorate for Education is critical about the quality of sexuality education.





The Netherlands

## Laws and policies on school sexuality education

In December 2012, the ‘law on educational goals’ for primary and secondary schools was adopted. This law supports comprehensive sexuality education. For primary education, core objective 38 states the following: ‘Pupils learn essentials about spiritual movements in the Dutch multicultural society who play an important role, and they learn to respectfully deal with sexuality and diversity within society, including sexual diversity’. For lower secondary education, core objective 43 states that ‘Pupils learn about similarities, differences and changes in culture and philosophy in the Netherlands, learn to see the relationship between their own lifestyle and that of others, learn to see the importance to society of having respect for one another’s views and lifestyles, and learn to deal respectfully with sexuality and diversity within society, including sexual diversity’.

There is also a ‘Law on School Safety’ (2015), which indicates that schools have to take care of social safety at school, including the prevention of sexual intimidation/sexual coercion and homophobia. However, sexuality education is not explicitly mentioned.

Sexuality education is partially embedded in the national objectives of education and mostly related to the more general objectives of health, citizenship and social safety. But schools are free in how they give substance to it. In a 2009 policy letter from the Ministry of Education, sexuality education is mentioned for the first time as an important part of education.

## Organisation and implementation of sexuality education

### Responsibilities

There is no national sexuality-education curriculum but only frameworks and guidelines. One deals with ‘relationships and sexuality’, another explains the main objectives regarding ‘sexuality and sexual diversity’. Both were developed by the Foundation for Curriculum Development, a semi-governmental institution. The guidelines are integrated into syllabi in a mostly comprehensive manner. Sexuality education is usually referred to as ‘seksuele voorlichting’ (sexual education) or as ‘relationele en seksuele vorming’ (relational and sexual formation). It is not a separate teaching subject but may be integrated into various other subjects, in practice mostly in biology, citizenship education, sociology or even mentor lessons. School boards, together with teachers’ organisations, NGOs and educational publishers, are responsible for the methods, programmes and teaching materials. The government is responsible for ‘what’ is taught, schools for ‘how’ it is taught. Schools can develop their own sexuality-education curricula or adopt those developed by others, taking into account the nationally formulated educational goals.

At the local level, Municipal Healthcare Centres are responsible for public health (including SRH), and they also have an important role in supporting schools by providing materials, lesson packages, advice and teacher training.

The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) have been used by ‘Rutgers’ (IPPF member association) and ‘SoaAids Nederland’, which are the most prominent NGOs in this field, for developing lesson packages.

The *Standards* have been translated into Dutch and adapted to national conditions and are widely used.

### Sexuality education in practice

The number of sexuality-education teaching hours varies widely, depending on the schools and the teachers. It is interesting to note that, at the time sexuality education became mandatory (2012), a national survey among young people aged 12–24 years<sup>1</sup> showed that the vast majority of them (92 % of boys and 93 % of girls) had already received sexuality education at school (most of them already several years before 2012). In fact, sexuality education started to be introduced in schools in the 1970s.

National NGOs like Rutgers, SoaAids Nederland and 'Movisie' develop lesson packages and sometimes support their implementation. Young people are often involved in their development and testing. Health professionals (often from the municipal health services) regularly support implementation. Because of the high degree of autonomy of schools and teachers, the topics addressed in schools may vary, but the results of the 2012 survey among young people<sup>1</sup> gave a good impression of the situation: 84 % of respondents mentioned having received information at school about contraception (including condoms); 79 % mentioned STIs and HIV/AIDS; 73 % pregnancy, birth and abortion; 54 % love and relationships; and 41 % homosexuality. About one-third of pupils received information on services in case of questions or problems.

It is estimated that 40 % of secondary schools use the lesson package 'Lang Leve de Liefde' (Long Live Love; 6 or 7 lessons for 13–14-year-olds) and 30 % of primary schools use the package

'Kriebels in je buik' (Butterflies in Your Stomach, consisting of 12 lessons for level 7 and 8 of primary school, i.e. 10–12-year-olds), formerly known as 'Relationships and Sexuality'. Most of the lesson packages developed by NGOs reflect a comprehensive approach and use participatory learning methods. Materials developed by publishers and educational materials for biology focus primarily on improving knowledge.

Only in primary schools is it suggested to involve parents. In most cases, this means that parents are informed about sexuality-education topics addressed in school, or they are supported with sexuality-education information in upbringing their children. For secondary schools, there is a sexuality education theatre play for parents. Especially NGOs like 'Rutgers', 'COC Nederland' (LGBT) and 'Edudivers' organise guest lessons on sexual diversity, and medical students are involved as peer educators.

There is little opposition to sexuality education in the Netherlands. Only in 2014, when the programme 'Dr Corry' was launched in school TV (see below), was there some opposition from conservative Christian groups. Their main arguments were that sexuality education would encourage sexual behaviour before marriage, that it is a private matter (not for the school), and that children are too young for it.

### Teacher training

Only few teachers are trained for sexuality education, and if they are it is in a short course, mostly a workshop on a specific topic. A formal competency in sexuality is not required, so that such training is not obligatory.



## Monitoring and evaluation

Some sexuality-education programmes have been evaluated (reports only in Dutch language), in particular ‘Kriebels in je buik’ and ‘Lang Leve de Liefde’ (see above). The results show that teachers and pupils alike usually appreciate these lessons. The effects found are mostly an improvement of knowledge, some positive attitude outcomes related to acceptance of sexual diversity, respect for sexual boundaries and a more positive intention to use a condom and (other) contraceptives.

Research by the Inspectorate for Education (2016) shows that the quality of delivery differs widely. Quality is mainly dependent on individual teachers. It turned out that sexuality-education lessons are often given in reaction to incidents, i.e. something that attracts the interest of the media. These can be isolated events and not goal-focused enough or structurally embedded in the curriculum and policy of the school. In other words, the Inspectorate is critical regarding the quality of the delivered lessons and the competence of the teachers. One of the conclusions of this report was also that the sexuality-education topics addressed did not vary across public schools/schools based on religion or schools in large cities versus small towns.

## Sexuality education outside the regular school setting

Extracurricular sexuality education is sporadic except for mass media. In the past, there were several TV programmes touching on it, and currently there is one called ‘Dr Corrie’ with weekly 20-minute episodes, discussing 20 different topics. They are watched by some 200 000 (mainly) young people aged 10–14 years. ‘Sense.info’ provides reliable information on

sexuality for young people 12–25 years old on the internet. It is quite popular with almost 2 million visitors per year (out of a total population of 17 million). Specialised NGOs also provide information via their websites.

There are special sexuality-education programmes for marginalised or high-risk groups, including young LGTB people, young people with physical or intellectual disabilities, young people in correctional institutions and young migrants. They all aim at affecting knowledge, attitudes and skills.

Apart from the programmes mentioned above, the following ones also deserve attention:

- ‘Leerlijn’ (Learning Line): a special education package for pupils with disabilities;
- Teacher Training College: lesson package ‘Over seks gesproken!’ (Let’s Talk About Sex!) for primary-school teachers;
- ‘Juf, doet u ook aan seks?’ (Miss, Do You Also Do Sex?) for training new biology teachers for secondary schools;
- ‘Seksuelevorming.nl’: a website to support teachers with information, tips and lesson packages to improve performance and stimulate them;
- ‘Lessenindiefde.nl’ (Lessons in Love): a website for teachers with films on how to deal with delicate situations in classrooms.

## Challenges and recommendations

Experts believe sexuality education still has to be improved, because there is a lack of

- criteria to assess the quality of sexuality education;
- an explicit curriculum for sexuality education;
- structural embedding of sexuality education in schools;
- implementation capacity;
- any feeling of urgency given the generally high standard of SRH in the Netherlands;
- evaluation of results of sexuality education;
- evaluation among young people of how they experience sexuality-education classes;
- uniformity in the quality of sexuality education in schools.

## Youth-friendly SRH services

There are no special youth-friendly SRH clinics or centres in the Netherlands (although there have been in the past). The special youth services that still exist provide only information and (telephone) counselling. The website 'Sense.nl', mentioned above, is the most important information service. It offers telephone and chat contacts. Furthermore, there is a 'children's telephone', targeting 8–18-year-olds, providing help for all kinds of questions and problems, though not specifically for sexuality. It is financed by private providers.

SRH (general) services are – in principle – free of charge for young people, but there are several restrictions. Consultation in primary healthcare (family doctor), where young people can get a prescription for contraception or an STI test, is free. The cost of other healthcare is covered by the mandatory 'basic health insurance', but for persons 17 and older there is an annual private co-pay of €385 (2016–2017). Because most young people are healthy and hardly use medical services, there is a fair chance that they will thus have to pay upfront, because the €385 has not yet accumulated. Contraception under age 21 is also free, but again above age 17 the private co-pay of €385 applies. Still, most young people from age 18 on can easily afford the cost of contraceptives, because they are relatively cheap.

STI testing is only free in special STI centres of the local health services for under-18s; above that age, the private co-pay risk applies once again.

Emergency contraception is available in drug-stores, without a prescription or age restriction, and it is quite widely used (12% of sexually active young people annually). Condoms can be bought in many places. Oral contraception and the IUD are free of charge up to age 21 (but with the private risk restriction). Other methods must be paid for. There is no age of consent for contraception, but for abortion it is 16 years. Abortion is free of charge for all women, due to a special governmental regulation.

## Data derived from surveys

The survey 'Sex under 25' (2012) included much data on young people's sexuality. The percentage of young people who had ever had sexual intercourse was 39% in the age group



## The Netherlands

15–17 years, 76% among 18–20-year-olds and 88% among 21–24-year-olds. There are virtually no differences between males and females in this respect. Nine out of ten adolescents use contraceptives at first intercourse. Almost three quarters of both boys and girls use a condom, and 50% of boys and 58% of girls use the pill or some other form of contraceptive. 34% of boys and 41% of girls use both condoms and oral contraceptives together ('double Dutch'). Four out of five sexually experienced young people reported always having used contraceptives during intercourse with their last sexual partner. 74% of sexually active girls used the pill, and 16% used other contraceptives, such as condoms or an IUD.

If Dutch adolescents have questions regarding sexuality, they mainly search for answers on the internet (65% of boys, 55% of girls) or talk to their same-sex friends (47% of boys, 63% of girls). Talking to their mother, however, is the next most frequently used option. Problems with regard to sexuality are most often discussed with friends, a steady partner or – again – one's mother.

A 2016 survey on behalf of 'Jeugdjournaal' (Youth Daily News) among 9–12-year-olds indicated that the first actual source of sexual information among children is their parents, followed by school and friends. The most preferred sources of information for them are parents and the school.



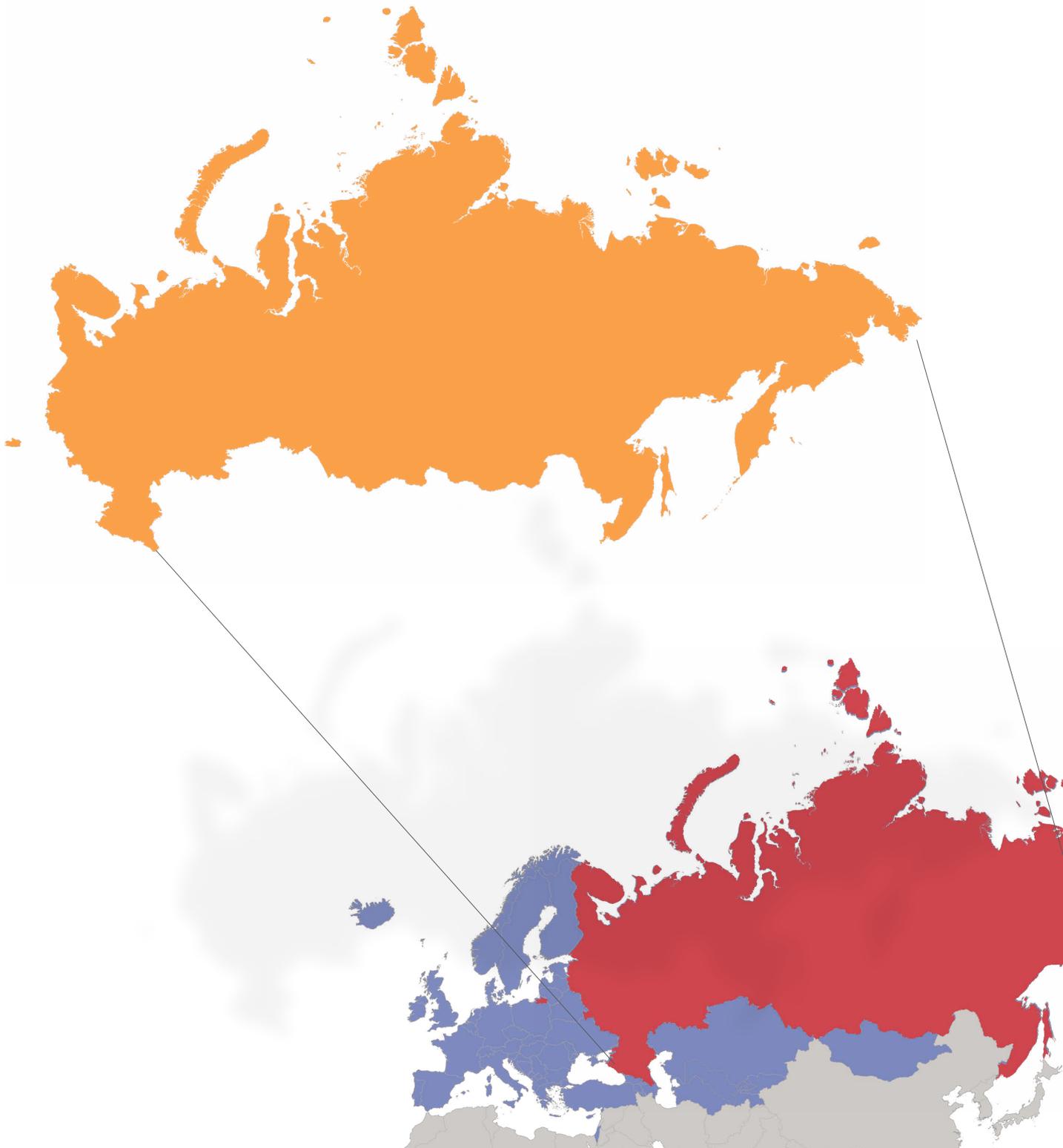
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## THE RUSSIAN FEDERATION

Because of the lack of political will and significant opposition, sexuality education today is not part of school curricula in the Russian Federation. However, many laws do support the promotion of healthy lifestyle skills and hygiene. Schools in the country mainly focus on preventive education.





The Russian Federation

## Laws and policies on school sexuality education

No laws or policies specifically regulate the inclusion of sexuality education in the formal educational system. The school system covers issues related to prevention education, which is mandatory for all educational institutions in all regions of the Russian Federation. According to the federal law on 'Prevention of Transmission of the Disease Caused by HIV in the Russian Federation' (federal law dated 30 March 1995 N 38-F3 edit. 23 May 2016<sup>1</sup>), the state guarantees 'inclusion of the thematic questions regarding moral and sex education into the educational programme' and does not allow HIV-infected people to be refused entry into educational institutions. In addition, a law 'On Education' (29 December 2012 N 273-F3, edit. 06.0.2015 N68-F3<sup>2</sup>) guarantees access to education for all children irrespective of their health status, and promotes conditions for their development and integration into the educational and social environment. Further, the law also foresees the 'promotion of and education on healthy lifestyle skills'.

The right to 'sanitary-hygiene education' is also stated in the law 'On Fundamental Healthcare Principles in the Russian Federation' (21 November 2011 N 323-F3, edit. 3 July 2016 N286-F3<sup>3</sup>). The Ministry of Education and Science, jointly with the Federal Service of Consumer Rights and Human Well-Being ('Rosпотребнадзор'), also developed a concept of preventive education on HIV for educational institutions. The concept includes the teaching of family values, a healthy lifestyle and respect for the individual person, the environment and the state among children and young people.

Despite the above-mentioned laws and the ratification of the European Social Charter in 2009

by the Russian Federation, there is presently no political will to implement a sexuality-education programme in the country.

## Organisation and implementation of sexuality education

### Responsibilities

Educational institutions develop the curriculum, but the teachers who deliver the subject are responsible for its practical planning. Invited healthcare workers may cover some topics. In addition, in some schools, programmes that were jointly developed with different religious organisations and the Russian Orthodox Church are implemented. NGOs are rarely involved in sexuality education in schools, though in the past they played a significant role in the promotion of HIV education. However, a law in the Russian Federation protects young people from receiving information that could negatively affect their health and development<sup>4</sup>. And sexuality education could be easily interpreted as containing such 'information'. This may be hindering access of NGOs to schools and the delivering of lectures or providing educational programmes surrounding sexuality education.

### Sexuality education in practice

Some elements of sexuality education, e.g. physiological aspects of the human body, pregnancy and birth, HIV, STIs, family and love, are integrated in other subjects such as biology, basics of life safety, and physical education for pupils aged 12 years and older. In some educational institutions, aspects such as HIV prevention, family relationships, family values and responsible parenting are presented during extracurricular hours or courses, but they are not systematically delivered and are initiated by

teachers or medical specialists. Very often topics related to reproductive health are left for self-study. Information on SRH services is not included in the above topics, though in some cases links to medical centres or resources are provided.

### Teacher training

Teachers do not get special training on issues related to sexuality education, which is reflected in the low coverage of health education for pupils and even fewer preventive activities in the field of reproductive health. In some cases, representatives of NGOs are invited to particular schools to provide training or workshops.

### Opposition to sexuality education

There is significant opposition to sexuality education in the Russian Federation from parents, church, traditionalists, and some federal and local parliament members. The main argument against sexuality education is the presumed 'negative influence of information related to sexuality on an adolescent's behaviour'.

### Sexuality education outside the regular school setting

Some NGOs have developed programmes for young people including vulnerable groups, mostly related to HIV prevention and life-skills development. For example, the Health and Development Foundation supported the implementation of a training programme called Everything That Concerns You, which reached more than 400 000 pupils in secondary and vocational schools and residential institutions across Russia. Designed for adolescents aged 13–17 years, the programme aims to improve health outcomes among adolescents, prevent risky

behaviour, HIV and STIs, and motivate young people to lead healthy lives.

With UNESCO support, an online resource, TEENSLIVE.INFO, was recently developed to provide adolescents in Eastern Europe and Central Asia, including Russia, with comprehensive information about SRH.

### Youth-friendly SRH services

Youth-friendly services, e.g. centres for adolescent SRH, can be part of medical dispensaries or polyclinics; these exist in a number of regions. They are either integrated into other medical services or can stand alone. Mostly these are governmental facilities, but sometimes they function under the umbrella of NGOs. None of them is privately organised.

Young people can receive SRH services for free. All services such as abortion, testing of STIs, etc., are included in the package of obligatory medical insurance. Some drugs/medications are provided in outpatient departments where the costs are covered by the individual, but inpatient provision of medication is free.

There is no legal age of consent for contraception. Usually healthcare providers do not inform parents of this matter, except when the adolescent is below 15 years old. For abortion services, girls under 15 years have to provide permission from their parents or caregivers. Emergency contraception is accessible in pharmacies for those aged 16 and over. Condoms are also sold in public places. Young people must pay for all types of contraception, and the high price is often a barrier for them. The cheapest options are condoms and emergency contraception. Additional barriers to obtaining contraception are shame and the



The Russian Federation

absence of knowledge of contraceptive methods among adolescents.

### Survey and vital data on young people's SRH

In 2011, a survey was implemented among 15–24-year-olds on behalf of UNFPA/CDC/Ministry of Health/Russian Statistics Committee called: 'Reproductive Health of the Population of the Russian Federation in 2011'<sup>5</sup>. The results showed that important sources of information about contraception for young people were friends (23 %) and doctors (11 %). For sexuality education (including pregnancy, menstruation, STIs, etc.), the most important sources of information were parents (34 %), friends (20 %), doctors (12 %), books (11 %) and finally teachers (8 %). 62 % of the sexually active young people had used a modern method of contraception during their last sexual intercourse, including 47 % who had used condoms and 11 % who had used the pill. A ROSSTAT survey in 2011 indicated that 55 % of pregnancies among 15–19-year-old girls were unplanned.

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## SERBIA

Sexuality education is still in an early stage of development in Serbia. Only very few elements are included in biology courses. From 2012–2015, there was a pilot project in schools in the Autonomous Province of Vojvodina. There is strong opposition to sexuality education in Serbia.





Serbia

## Laws and policies on school sexuality education

There is presently no national law or policy on sexuality education in Serbia, nor is there a national sexuality-education curriculum. Only very few sexuality-education topics are included in biology classes, and these are strictly limited to body awareness and reproductive functions. This biology chapter comprises 6 teaching hours. Biology, which is taught in both primary (or 'elementary') and secondary schools, is a mandatory subject. Only for optional courses do parents have to give their consent for their children to attend classes.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministry of Education is responsible for the final decision whether sexuality education (as well as every other subject) is approved and provided, but at the provincial/regional/local level, some programmes can be, and actually have been, approved. One of those programmes, initiated and conducted by the Provincial Secretary for Sports and Youth on the territory of the Autonomous Province of Vojvodina, is 'Health Education on Reproductive Health'.

### Sexuality education in practice

The programme in Vojvodina, which was developed jointly with the Institute of Public Health of Vojvodina, covered most of the schools and was implemented during the period 2012–2015. It was not just about learning about reproductive health, but also included education for high-school pupils on gender equality and human rights. The teachers who participated in

this pilot project were specially trained to deliver the programme. It included two pre- and post-implementation studies on the knowledge and attitudes of young people before and after the course. The conclusion drawn from this study was that this programme is needed in schools because it is primarily about pupils' health and rights. In 2015, the provincial authorities decided not to continue funding the programme. The reasons for this are not exactly known, but it seems that it has been a combination of insufficient political will and opposition to the programme.

## Sexuality education outside the regular school setting

A few sexuality-education curricula have been developed, mostly by NGOs and educational and medical professionals. These curricula are mostly used for informal education. Currently, 'SRH Serbia' (IPPF member association) conducts training courses on various topics relevant to SRHR under the new programme 'Skills, Knowledge and Techniques for Preventing and Reducing Gender-Based Violence and Discriminatory Behaviour in the School Environment'. To date, however, there are no teaching materials or guidelines available, except for the ones that were developed for the pilot project in Vojvodina. This new programme deals with various topics that are relevant for sexuality education. The educational materials and guidelines being prepared are for teachers, peer educators and pupils and will be disseminated during training and educational sessions.

'SRH Serbia' also provides informal peer (sexuality) education under the project 'Drop-in Centre for Human Rights', reaching various vulnerable groups such as LGBTI people, Roma, young people living with HIV/AIDS, people living with disabilities, sex-workers and women and girls in general.

Some other NGOs periodically implement programmes related to topics of sexuality education, usually through peer education. The main issues addressed in such programmes are contraception, STI and HIV prevention and treatment, sex-positive approaches, gender equality and prevention of gender-based discrimination and violence, gender identity and sexual orientation.

### Opposition to sexuality education

There is serious opposition to sexuality education in Serbia, mainly from the Ministry of Education, teachers and other school staff as well as parents. The main arguments against it are related to the presumed ‘inappropriateness’ of the topics for youth. An important political concern related to reproductive health in general concerns the governmental objective to increase the (low) birth rate, and as a result addressing issues like gender equality, prevention of unwanted pregnancies and STIs, the right to choose, and sexual orientation are not seen as necessary, let alone desirable.

Supporters of sexuality education feel that it is necessary to advocate introducing sexuality education in schools because they feel it represents one of the most important interventions for protecting and promoting reproductive and sexual health, but also – and equally important – for achieving gender equality, empowerment of girls and women, and equity for all.

### Youth-friendly SRH services

According to a 2011 overview, there are over 35 Counselling Centres for Family Planning in public health centres across Serbia: 10 in Belgrade, 7 in Vojvodina, 8 in Central Serbia, 2 in Western Serbia and 9 in South and Eastern Serbia. Additionally, there are a few counselling centres run by private

health centres. The capacities and types of services offered by these counselling centres vary, but they mostly focus on counselling on STIs, contraceptive methods and sexual education, through interviews with adolescents, pregnant women or couples. They may also organise workshops. They provide two types of counselling for young people: counselling for older minors and developmental counselling (for pre-school children and children with developmental problems).

Gynaecologists in Primary Health Care Centres perform contraceptive counselling, focusing mostly on adolescents with special needs. At the national level, these SRH services are provided largely by the government. Private providers and NGOs usually provide them at the local level. Opinions on the activities and functionality of these centres differ. Some feel that the counselling of young people should be friendlier, and that a more holistic approach is needed with young people.

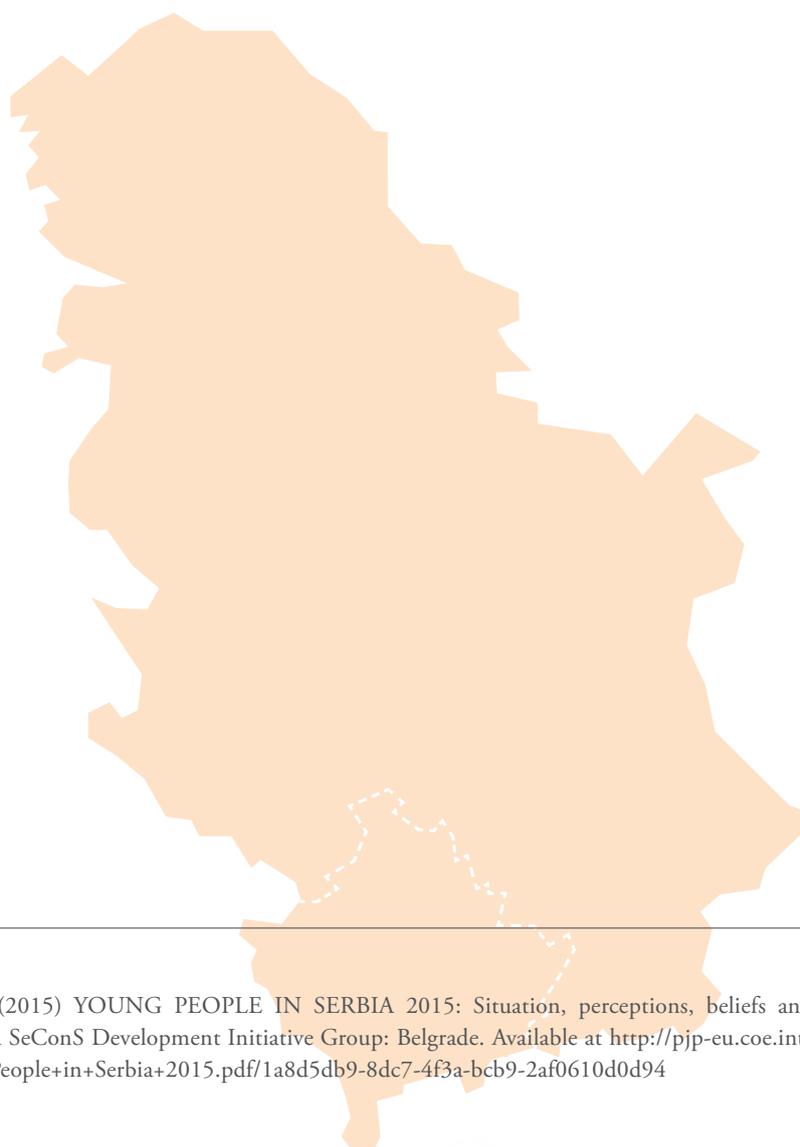
Except for STI treatment, all SRH services are free of charge to young people. Nevertheless, there are barriers to using these services. Most young people do not know them, and the quality of the services is often considered not good or they are not provided in a youth-friendly manner. Emergency contraception is available from pharmacies without prescription. Condoms can be bought in various public places such as kiosks, drugstores, supermarkets, etc. But they are often too expensive for young people, costing about €1.50. Other contraceptives are also not available for free, or at a reduced price for young people, and several methods are not available in Serbia at all (including the vaginal ring, contraceptive patch, injectables and implants). Abortion carries an age of consent of 16 years.



Serbia

### Some survey and vital data on young people's SRH

According to a 2015 survey among 15–24-year-olds, 79.6% were sexually active, of whom only 33% were using a modern method of contraception.<sup>1</sup>



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## SPAIN

The legal basis for sexuality education in Spain is weak, but in practice it is firmly fixed in the curricula of many schools. Initiatives to integrate sexuality education in school curricula depend on local authorities and schools. NGOs play an important role in delivering sexuality education in schools.





## Laws and policies on school sexuality education

No law in Spain requires schools to deliver sexuality education, nor is there a national sexuality-education curriculum. In 2010, the Ministry of Health issued the ‘Organic Law 2/2010 on Sexual and Reproductive Health and Abortion’. The objectives were to guarantee fundamental rights in the field of SRH, to regulate the conditions of abortion in Spain and to establish the corresponding obligations of public authorities regarding these issues.

In the development of this law, sexuality education appeared only as a recommendation, and no reference was made to its approach and contents. It only says: ‘This law is developed with the conviction – supported by the best scientific knowledge – that appropriate sexuality education is the most effective tool to prevent, especially in young people, sexually transmitted infections, unwanted pregnancies and abortions.’ The law stipulates that ‘the public authorities, in the development of their health, educational and social policies, shall ensure information and “affective-sexuality education”<sup>\*</sup>. Preventing the risks of sexual behaviour is the core objective of this law. But the recommendation on sexuality education was not implemented in this way. The ‘public authorities’ mentioned are in practice regional and local authorities. The latest education law (2013) makes no reference to sexuality education at all.

\* Sexuality education including more than biological aspects, in particular relational and emotional aspects.

## Organisation and implementation of sexuality education

### Responsibilities

In practice, sexuality education is delivered in the form of short workshops, which are usually called ‘Workshops in Affective-Sexual Education’. It is common that they are integrated into wider programming about health education. It is very unusual to find schools where sexuality education is delivered by teachers, which is only the case if teachers have been specially trained for it – which is rare. Instead, sexuality-education workshops are usually implemented by a wide variety of external organisations. Local authorities have an important say in this.

- In some cases, the local authorities actually promote these workshops, by hiring public or private organisations to develop and facilitate them.
- In other cases, sexuality-education workshops are conducted by people hired by the local authority, which determines the guidelines for their execution.
- Sometimes, local authorities determine the content of these workshops and regulate them.
- Finally, there are cases in which local authorities prohibit workshops, ban certain organisations or decree that pupils need parental permission, so that parents can participate.

The focus on risk prevention mentioned above does not forestall a wider interpretation because, besides prevention of STIs, HIV, unwanted pregnancy and abortion, sexuality education is linked also to the following objectives:

- promotion of a vision of sexuality in terms of equality and shared responsibility between men and women, with special attention paid to the prevention of gender-based violence, sexual assault and abuse;
- recognition and acceptance of sexual diversity;
- harmonious development of sexuality in light of the characteristics of young people.

Parents or families are sometimes involved in sexuality education, but this is not a widespread practice. Some NGOs rely on specific funding to develop workshops on sexual education aimed at families. Some local governments and schools even ask for workshops that include the participation of families, or the families themselves organise sexuality-education workshops.

### Sexuality education in practice

The actual content of sexuality education varies widely, depending on the local authority, school and implementing organisation. Once they have decided to organise a workshop, it is mandatory for all pupils. In some autonomous communities, parents must authorise the participation of their children.

Local authorities and schools generally request workshops for pupils aged 12–16 years, as part of secondary education. It is unusual that all classes from one school participate in a workshop; rather, those groups that are supposed to have a greater need are chosen. Sometimes there is also no continuity to the workshops afterwards. Normally, a workshop lasts two sessions of one hour each.

Since there is neither a national curriculum nor consensus concerning the contents of the workshops, the choice of contents depends

on the organisation giving the workshop. The choice corresponds to the demands made by the local government or the school itself, which usually indicates what approach they want the workshops to have or what specific issues they want to be addressed. It is important to note that implementing organisations are selected based on these needs. Usually, the approach tends to focus on prevention of risks related to sexuality.

In some (rare) cases, particularly interested teachers themselves carry out sexuality-education workshops within the framework of the subjects they teach. The pupils can rarely influence the contents of those workshops, although in some cases their questions and interests are collected beforehand. Sometimes religious organisations give workshops and then decide on the contents. The same applies to health professionals and NGOs.

The table presents a rough impression of the topics addressed in the workshops and how often they tend to be addressed (depending on the requesting and implementing organisation).

In most workshops, participants are informed about services they can access. If a workshop is conducted by the Spanish Federation of Family Planning (FPFE; IPPF member association), professionals offer information about the four youth-friendly services the organisation manages.

### Teacher training

There is no official sexuality-education training for teachers. Some interested teachers participate in training courses on their own initiative, in order to acquire the knowledge and tools they need.

There are some educational materials and guidelines, developed by NGOs trying to provide



Main topics dealt with	How often addressed?		
	Often	Sometimes	Hardly
Biological aspects and body awareness	X		
Pregnancy and birth	X		
Contraception (including at least three effective methods)	X		
HIV/AIDS	X		
STIs	X		
Love, marriage, partnership		X	
Sexual pleasure		X	
Sexual orientation		X	
Gender roles	X		
Online media and sexuality		X	
Access to safe abortion in the framework of the national law			X
Mutual consent to sexual activity		X	
Sexual abuse/violence			X
Domestic violence		X	
Human rights and sexuality			X
Sexual identity			X
Models of beauty, self-esteem and self-concept			X

the knowledge and tools teachers need, but they do not respond to all the teachers' needs. The FPFE published one of these guides with specific funding from the Ministry of Health, aiming to provide some clues to the development of sexuality education activities in the classroom as well as to provide methodological resources. Most of these materials reflect a comprehensive approach, although large parts of the guidelines are dedicated to the prevention of unplanned pregnancies, STIs and HIV. All guidelines offering methodological resources are based on participatory approaches, trying to facilitate meaningful learning by pupils through activities such as brainstorming, discussions or work on specific cases.

### Monitoring and evaluation

There is no systematic evaluation of sexuality education at the national level. Some projects try to evaluate specific experiences in some schools and cities. After most workshops, participants fill out a short questionnaire aimed at assessing their satisfaction with the workshop and the knowledge acquired. They are used to get a general idea of the degree of compliance with the objectives of the workshop.

### Sexuality education outside the regular school setting

FPFE conducts comprehensive sexuality-education workshops both in its own four youth-friendly

clinics and other youth-oriented spaces, and it gives such workshops with other NGOs working with young people (especially with vulnerable ones). Besides the FPFE, there are at least five other NGOs involved in sexuality education, mostly targeting their own focal vulnerable or high-risk groups (LGBTI, sex-workers, drug addicts, young people with physical or mental disabilities, young (undocumented) migrants, etc.). Examples of such programmes, including some implemented (partly) in schools, are:

- a programme by the FPFE in correctional institutions – a highly specific group – in which the organisation works not only with young people, but also with directors and educators;
- ‘Harimaguada’, an icon of sexuality education in Spain, which developed the first sexuality-education guidelines for teachers when the first law that included sexuality education in the official curriculum was launched and continues to develop important materials such as the ‘Sexpresan’ guidelines;
- ‘Astursex’, is an organisation managed by sexologists, combining sexuality-education workshops in most of the schools in Asturias with information centres;
- ‘Asexórate’, a member of FPFE, which holds workshops in which prevention of gender violence plays a fundamental role, and has published a guide for young people called ‘Don’t love me so much, love me well’, complemented by numerous prevention activities.

There are also radio and TV sexuality-education programmes, such as those developed by the organisation ‘Amaltea’.

## Opposition to sexuality education

Comprehensive sexuality education in Spain faces much opposition, especially among conservative groups (political parties, religious groups, family groups, etc.). The two main arguments against sexuality education are:

1. Sexuality education should take place within the family. It is the family and not the school who must decide the values children should learn in relation to sexuality.
2. Sexuality education provided by those who defend sexual and reproductive rights, like the FPFE, is full of messages that can alter young people’s morals (gender ideology, defence of homosexual people, legitimisation of abortion). These workshops indoctrinate the affectivity and sexuality of young people without the knowledge and consent of their parents.

## Challenges and recommendations

Supporters of sexuality education contend that sexuality education should become a part of the official curriculum and be regulated by a law issued by the Ministry of Education. The FPFE defends their stance that it must also be a specific subject developed by teachers with support of expert organisations, using scientific approaches. It must be free of ideologies and moral criteria, and it should address a concept of sexuality which is broader than purely biological aspects. It is, therefore, necessary that teachers have access to quality training, accompanied by materials and resources. Sexuality education must also be complemented by youth-friendly services.



### Youth-friendly SRH services

There are about 20 youth-friendly SRH centres offering a wide and varied range of SRH services. The number of centres offering only information is even higher. In recent years, the lack of funding has forced many centres to reduce their services or even close their doors completely. The FPFE manages four of these centres in the cities of Madrid, Albacete, Coruña and Barcelona. Their services are provided separately from other health services. In most cases, the services are provided in specific spaces that are exclusively set aside for young people. Close to half of these centres are operated by a few NGOs, and local governments provide the rest. All centres share the same philosophy.

SRH services are free of charge for young people who have a legal status in the country. For illegal immigrants, however, service cost can be a serious barrier. Contraceptives are in principle not free of charge, though in some centres condoms and emergency contraception are available for free, and oral contraception, IUDs, and injectables are partly funded by the public health system. In recent years, funding for third-generation oral contraceptives by the public health system has declined. The cost of emergency contraception is much higher than in other European countries.

The age of consent for contraception is 16 years, but between 13 and 16 years, professionals can decide whether the young person is mature enough to make own decisions. For abortion, the age of consent is 18 years.

### Data derived from surveys

According to a 2013 survey among 14–18-year-olds, the most important sources of information about sexuality are the internet and social media (33%), friends and peers (32%), school (22%) and parents (12%). Almost two-thirds of the sexually active 15–24-year-olds use a modern method of contraception. 13% of the same age group have had an STI<sup>1</sup>. The HIV infection rate in 2015 was 7.4 per 100 000 inhabitants, and 3.5 per 100 000 in the age group 15–19 years<sup>2</sup>. These rates are much lower than a decade before.

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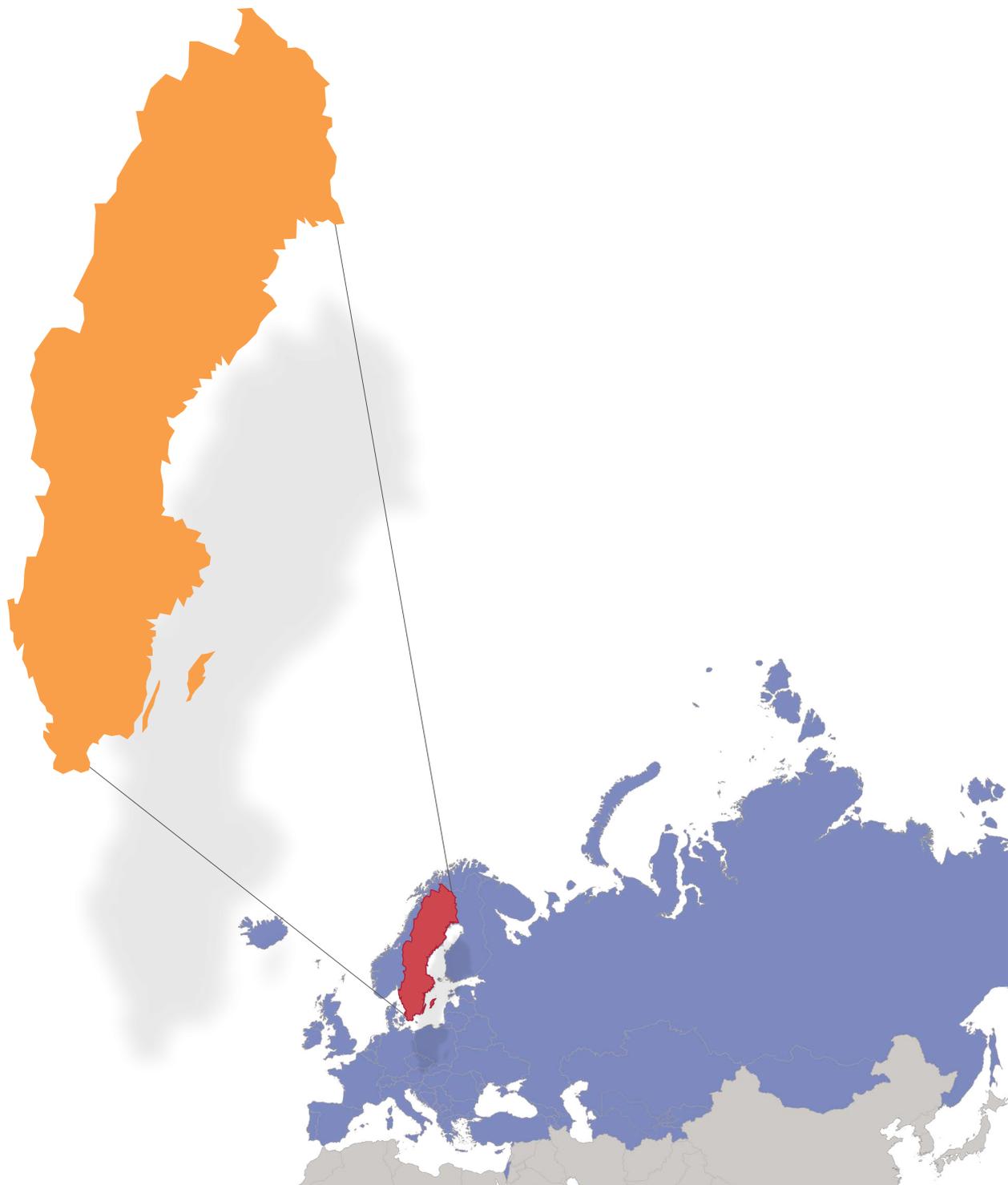
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## SWEDEN

In 1955, Sweden was the very first country to introduce mandatory sexual education in schools. Since then the subject has gone through a long process of evolution, along with changing conditions, incorporating new elements and reflecting new evolving visions in people and society. Sexuality education is today fully integrated in school curricula and addressed in a variety of teaching subjects.





Sweden

## Laws and policies on school sexuality education

The current teaching of sexuality and relationships is based on the 2010 Education Act (SFS 2010:800) on gender equality, which says that schools should ‘actively and consciously further equal rights (...) for women and men’. This has resulted in two new curricula: the Curriculum for the Compulsory School, Preschool and the Recreation Centre 2011, and the Curriculum for Upper Secondary School 2011. The subject is generally referred to as ‘Sexuality and Relationships Education’. Concepts such as sexuality, relationships, gender, gender equality and gender norms have been included in several of the courses and subject syllabi for compulsory and upper secondary school since 2011. This means that the responsibility for including sexuality education falls on several teachers, and that it is brought up in the scope of multiple courses and subjects. The governance documents indicate that some subjects are particularly important in the efforts to impart knowledge about gender equality, sexuality and relationships, as the corresponding course and subject syllabi contain several aspects of sexuality education. At the same time, sexuality and human relationships, in the broader sense, are but one aspect of the work necessary to instil fundamental values. Therefore, all teachers can be involved, regardless of their subject(s). Biology and Science Studies deal with knowledge of the human body, reproduction, sexuality and sexually transmitted diseases. However, concepts such as gender equality, responsibility, global levels and historical perspective have been added to the course syllabus, which reinforces the cross-disciplinary perspective.

The overall goal of the current policy is for pupils to develop their knowledge about SRHR, STIs, reproduction, the human body, contraceptive

methods as well as voice their questions about norms, identity, gender, gender equality, sexual orientation and relationships. Its aim is also to develop respect for diversity among the pupils. Sexuality education is fully comprehensive in character.

## Organisation and implementation of sexuality education

### Responsibilities

The National Agency for Education is the central administrative authority for the public-school system. The Swedish Parliament and the Swedish Government define the goals and guidelines for preschool and school education through the Education Act and the Curricula. The mission of the National Agency for Education is to actively work to attain the set goals. The municipalities and the independent schools are the principal organisers in the school system; they allocate resources and organise activities so that pupils can attain the national goals. The Agency supervises, supports, follows up and evaluates schools in order to improve quality and outcomes. It also determines the syllabi, which are then authorised by the Ministry of Education. ‘Consultation groups’ also give input. These include educational professionals, young people, NGOs, the Public Health Agency of Sweden and the Swedish Agency for Youth and Civil Society. The head teacher of each school has a direct responsibility for ensuring that ‘teaching in different subjects integrates cross-disciplinary areas of knowledge, such as the environment, traffic, gender equality, consumer issues, sex and human relationships, and also the risks inherent in tobacco, alcohol, and other drugs’. Some NGOs give lectures in schools and perform other educational activities. Parents, however, have no influence over the curriculum.

## Sexuality education in practice

Because sexuality education is spread out throughout the entire educational programme, starting in pre-school and continuing through upper secondary school, it is impossible to indicate the exact number of teaching hours dedicated to it. Some schools spend more hours on it than others. Most schools focus on sexuality education in grades 5–6 (11–13 years) and 8–9 (14–16 years).

Topics that are included extensively in the curricula are biological aspects of sexuality and body awareness, pregnancy and birth, contraception, abortion, STIs, love, long-term relationships and partnership, sexual orientation, gender roles and equality, mutual consent to sexual activity, and human rights and sexuality. Issues that are taught more briefly are HIV/AIDS, sexual pleasure, online media and sexuality, sexual abuse and violence as well as domestic violence. However, other topics could also be interpreted as involving aspects of sexuality and relationships, such as sexuality in different religions, identity, medical ethics, and values and norms. The syllabus allows for variation and is flexible enough to be arranged in different ways. Online media and sexuality as well as pornography are topics that a lot of teachers think are important but difficult.

## Teacher training

Most teachers receive some training in sexuality education. During teacher training, it is compulsory only for those who will eventually teach grades 4–6. Most teachers also receive some training in gender-related issues and discrimination, but this is not focused specifically on sexuality. Some schools have specially trained ‘gender educators’. Many teachers also

participate in different in-service training courses or seminars on sexuality education, arranged by counties, universities, municipalities, NGOs like RFSU (The Swedish Association for Sexuality Education, IPPF member association) and RFSL (Swedish Federation for Lesbian, Gay, Bisexual, Transgender and Queer Rights). Some of them are 1-day events, others 2–3 days and a few are even longer. Gender is now included in teacher training at university. Between 2009 and 2014, the Swedish Agency for Youth and Civil Society arranged for university courses on young people and the internet, in which several teachers participated. The National Agency for Education also arranged for university courses on teaching sexuality and relationships between 2009 and 2014 as well as organising 10 regional conferences on sexuality education in 2014.

Teacher guidelines and other educational materials are available. These materials reflect comprehensive and participatory learning approaches. They have been developed by different NGOs and the Swedish National Agency for Education.

## Monitoring and evaluation

There is no monitoring system for the implementation. A process evaluation was conducted in 1999 which surveyed 80 schools. The main result was that sexuality education varied from one school to another and even within schools, depending on the teacher. At that time, very few schools had specific objectives/goals for sexuality education written down in a work plan. The evaluation led to an update and revision of the sexuality-education curriculum. The Department of Education recently decided to make an evaluation of sexuality education during 2017 and then propose measures to improve or further develop it. The government also announced



Sweden

activities for schools on working with masculine behaviour, specifically on preventing sexual harassment and violence.

### Sexuality education outside the regular school setting

Several organisations, including NGOs, youth centres and various media, provide extracurricular sexuality education. It is not exactly known what kind of education is provided for vulnerable young people, but such activities are available for young LGBTI people, young HIV+ people, young sex-workers and young people living with a physical or intellectual disability. For other vulnerable groups such activities are uncommon, because they are (supposed to be) reached by schools and educational campaigns.

### Good practices and initiatives

When asked for examples of good practices, the Swedish school curriculum and syllabus are mentioned first as well as campaigns by NGOs. Some other interesting examples are:

- ‘Sexuality Education in Easy Swedish’ – teacher guidelines for people working with migrants. Also, three 3-hour sessions for newly arrived migrants (both school youth and adults).
- ‘Sex on the Map’ – an animated educational film for schools.
- ‘The World’s Most Important Book’ – textbook for sexuality education for 10–13-year-old pupils.
- ‘UMO.se’ – a very extensive website about sexuality, health, the human body, relationships and related issues.

### Challenges and recommendations

- More and better follow-ups, M&E.
- Research on didactic issues, e.g. classroom research about how sexuality education is done in the classroom and what works and what doesn’t.
- Compulsory pre-service training for all student teachers – presently it is compulsory only for those who are going to teach grades 4–6.

There is no significant opposition to sexuality education in Sweden.

### Youth-friendly SRH services

There are links between sexuality education and youth-friendly SRH centres. School classes usually pay visits to these centres. These are run by the government and NGOs or as private practices. Normally, they are separate special youth clinics. There are also links by references to websites like [www.umo.se](http://www.umo.se), which is a ‘youth clinic on the net’. Young people do not have to pay for SRH services nor for induced abortion, which is legal on demand up to 18 weeks gestation. Emergency contraception is available from pharmacies without a prescription, and condoms are for sale in supermarkets, drugstores and many other outlets. They are also available in youth clinics and in many schools. Young people have to pay for other contraceptive devices, but these are subsidised for persons under 25 years so that the price is not a real barrier. A year of subsidised contraceptive pills costs about \$10. Interestingly, there is no age of consent for obtaining contraception, nor for having an abortion.

## Data derived from surveys

A survey of young people's knowledge, attitudes and behaviour was conducted by the University of Gothenburg and published in 2011<sup>1</sup>. The study included a few questions on sexuality education and sexual health. The main results are summarised below in the table.

### Evaluation of school sexuality education by former pupils

Question	Yes		Yes, but too little	
	Male	Female	Male	Female
Did you acquire knowledge that you could use to take care of your sexual health?	79 %	77 %	32 %	24 %
Did you acquire enough knowledge on condom use?	64 %	54 %	22 %	32 %
Did you acquire enough knowledge on how to prevent unwanted pregnancy?	73 %	66 %	18 %	25 %
Did you acquire enough knowledge about HIV?	50 %	39 %	35 %	45 %

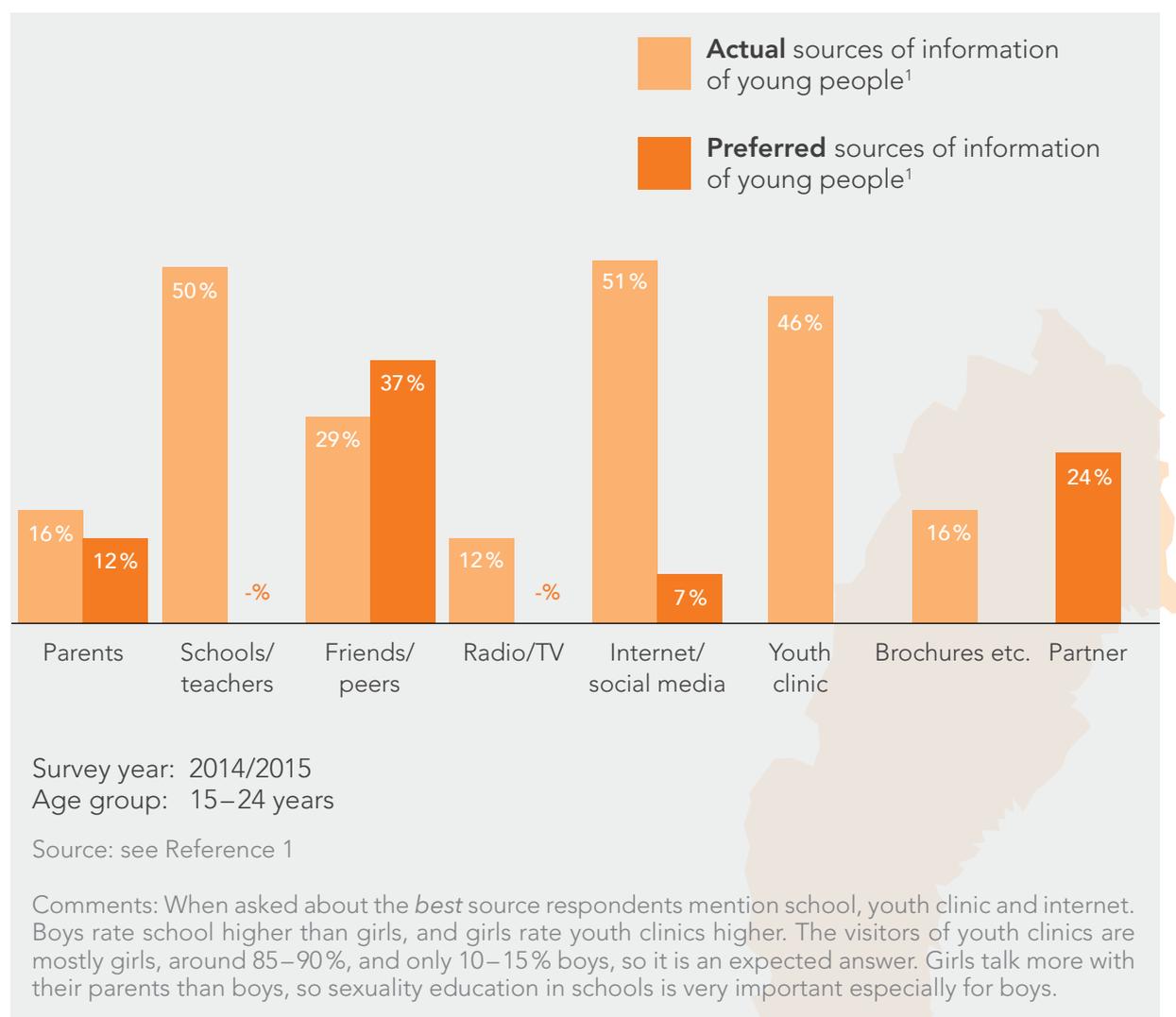
The graph shows what the importance is of school sexuality education in comparison with other sources.

The average age of first intercourse in 2014/2015 was 16.0 and 16.4 years for girls and boys, respectively<sup>2</sup>.



Sweden

### Actual sources of information and preferred people to talk with about sexuality and related issues among young people

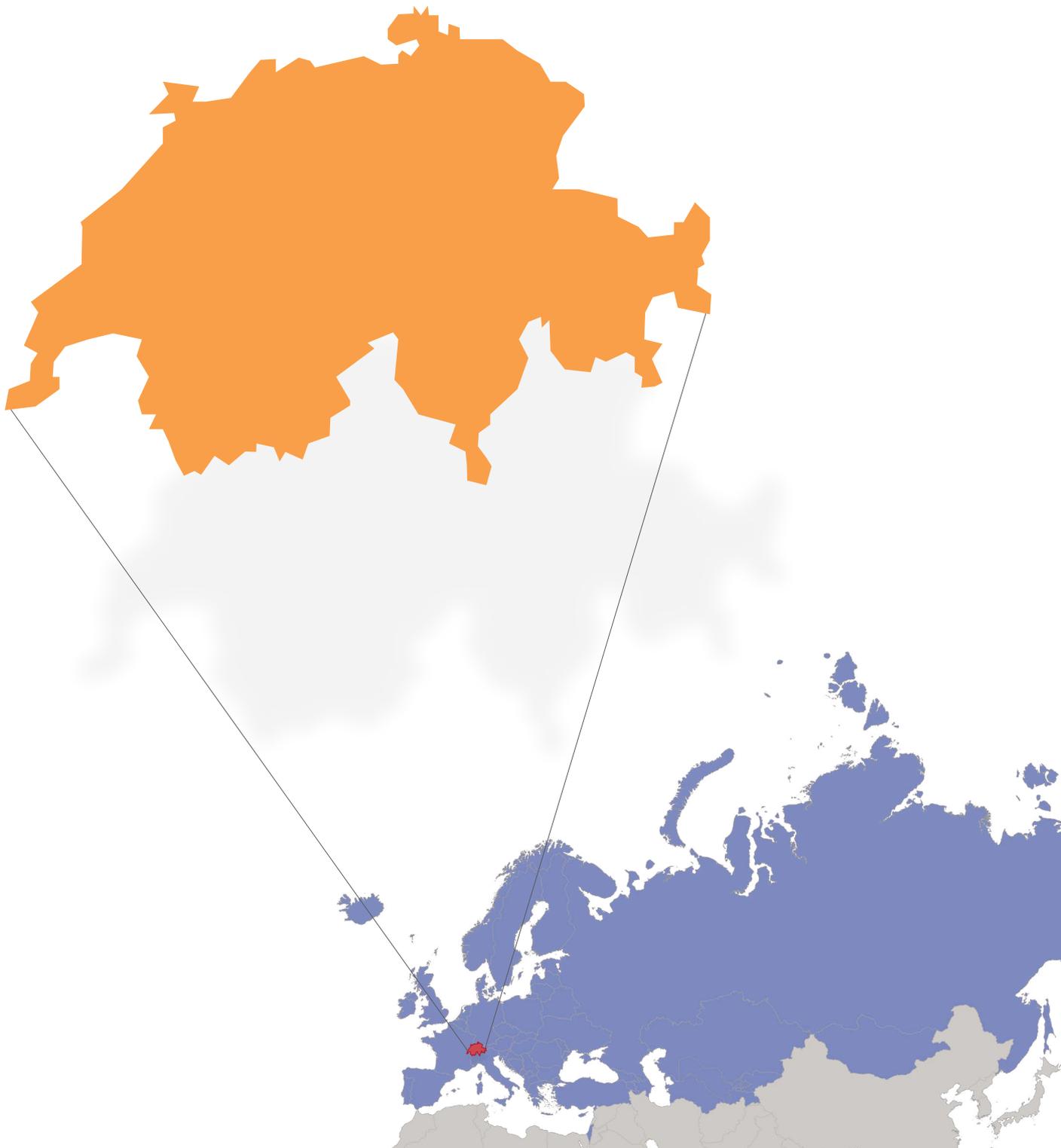


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## SWITZERLAND

Sexuality education in Switzerland is well developed. Lessons commence early, between the ages of 4 and 8 years, and continue through secondary school. There are some differences between the three lingual regions of the country. Switzerland has the lowest teenage pregnancy rate in Europe.





Switzerland

## Laws and policies on school sexuality education

Switzerland is divided into cantons, which have a high degree of autonomy, not least in the area of education, including sexuality education. The cantons are fully responsible for the implementation of the latter. Frameworks for sexuality education are included in the 'Plan d'Études Romand' (Education Plan of Romandy) adopted in 2009 in the French-speaking cantons in the west and southwest of the country; in the 'Lehrplan 21' (Educational Plan 21; 2014) in the German-speaking cantons in the North; and in the 'Linee guida per l'educazione sessuale nella scuola' (Guideline for school sexuality education; 2008) in the (partly) Italian-speaking cantons of the southeast. Educational objectives are included in these frameworks, but there is no overall goal for sexuality education. The frameworks are comprehensive in character.

Sexuality education is implemented both as a separate subject and integrated into wider subjects. In the German-speaking cantons, it is included in 'Natur, Mensch und Gesellschaft' (Nature, Humanity and Society), in 'überfachliche Themen' (General Subjects), and in 'Lebenskundliche Themen' (Life Science Subjects). In the French- and Italian-speaking cantons, it is included in 'Gesundheit und Wohlbefinden' (Health and Well-Being) and in 'Diversität' (Diversity). The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) were used as a guide to ensure that sexuality-education curricula were comprehensive, and for advocacy purposes. This was not done officially by the administrations but by NGO experts. As part of the wider subjects, sexuality education is mandatory, but with the possibility of opting out. However, this option seems to be used only sporadically. The number of teaching hours is not defined.

## Organisation and implementation of sexuality education

### Responsibilities

The Ministries of Education of the individual cantons are responsible for curriculum development. They are supported by different advisory groups, such as teachers and other educational specialists, healthcare professionals (in the French- and Italian-speaking cantons), church authorities (in the Italian-speaking cantons), and specialised NGOs. NGO involvement in the teaching of sexuality education is more prominent in the French and Italian-speaking cantons than in the German-speaking ones.

### Sexuality education in practice

All relevant subthemes of sexuality education are included in the curricula, and most of them are dealt with extensively, including access to abortion, mutual consent to sexual contact and gender. Subthemes that receive comparatively less attention are sexual pleasure, sexual orientation, domestic violence and human rights related to sexuality. It should be emphasised, however, that there is much variation throughout the country. The parents of pupils are not explicitly involved in the teaching of sexuality education. Information is sometimes provided to them in advance, especially if external specialists are providing the lessons, but this depends on the canton and on the teacher. In the French-speaking cantons, schools involve external specialists in sexuality education for 9 to 15 hours.

Normally the teacher or the sexuality-education professional provides the information and addresses of sexual-health services. But that does not always happen, and it differs substantially between the individual cantons and communities.

In the 'Educational Plan 21' for the German-speaking cantons, for example, it is explicitly mentioned that information about services should be provided.

### Teacher training

Teacher training in sexuality education also differs widely between the different parts of Switzerland. Almost all teachers are trained in the French-speaking part. In the German-speaking part, few are trained and these for less than 1 day. Educational materials and teaching guidelines are available from publishers of school materials and from the national SRHR-NGO ('Sexuelle Gesundheit Schweiz'; Foundation for Sexual Health Switzerland). Those materials reflect participatory approaches in sexuality education.

Also, the materials used vary between the different parts of Switzerland. In the Italian-speaking part, canton Ticino offers a platform with materials. In the French-speaking part, educational support organisations offer materials of their choice. In the German-speaking part, each organisation or institution uses materials of its choice. Sexual Health Switzerland is an important source of materials in this part of the country as well.

There is no systematic system of monitoring or evaluating the quality of implementation of sexuality education.

### Sexuality education outside the regular school setting

Various extracurricular sexuality-education activities have been implemented. Professional sexuality-education organisations and some peer-education groups provide information on most subjects. Some student organisations and religious organisations provide lessons on reproduction and

natural contraception. Online channels, like those of professional SRHR-NGOs at the national and cantonal level, give information about all matters concerning sexuality of young people. Special educational programmes target young LGBT people and young people with physical or mental disabilities, through various projects and specialised schools. However, these programmes by no means reach all targeted young people in the country.

### Opposition to sexuality education

There is some opposition to sexuality education in the country, mainly from conservative groups. Since 2014, political debates have been going on at the national level about comprehensive sexuality education. A public initiative against sexuality education was launched, and the matter was discussed in Parliament in 2014 and is still going on<sup>1</sup>.

There is also opposition to the concept of 'sexual orientation' and to idea of 'emancipatory' (i.e. comprehensive) approaches. Opponents argue that society and especially children and young people need ethical values and norms, and that these should not be everybody's free choice. Some (smaller) religiously motivated groups express opposition toward gender-sensitive approaches.

### Recommendations

- More attention should be paid to the objectives of sexuality education, the methods of teaching and to measuring impact.
- For political discussion, there is a need for arguments in favour of sexuality education and governance should be strengthened.



- There is a need to enter into dialogues with those opposed to sexuality education, instead of avoiding this discussion.

### Youth-friendly SRH services

There are no specially labelled youth-friendly SRH services in Switzerland, but young people rarely have to pay for regular service delivery. The only exception is their having to pay something for STI and HIV testing if they want it done anonymously. Costs for testing are not supposed to be a substantial barrier for most young people, but they can be for some groups, like persons at risk of HIV infection and/or STIs. Emergency contraception is available in pharmacies without a prescription, and there is no lower age limit for obtaining it. But emergency contraception and other types of contraception have to be paid for, and this may be a barrier for relatively poor young people. Condoms are sold in many places, like supermarkets, etc. There is no age of consent for obtaining contraceptives nor for abortion.

### Some survey and vital data on young people's SRH

It should be mentioned that Switzerland has the lowest teenage birth and abortion rates in Europe (1.8<sup>2</sup> and 3.4 per 1 000 15–19-year-old girls<sup>3</sup>, respectively). There are some survey and registration data on STIs and HIV. Data from 2015 for young people 15–24 years old indicates that the incidence of diagnosed STI infections in this age group was 7.35 per 100 000 for syphilis, 45.5 per 100 000 for gonorrhoea, and 484 per 100 000 for chlamydia. The incidence of HIV infections was 5.64 per 100 000 in 2015 (in absolute number: 53 cases)<sup>4</sup>.

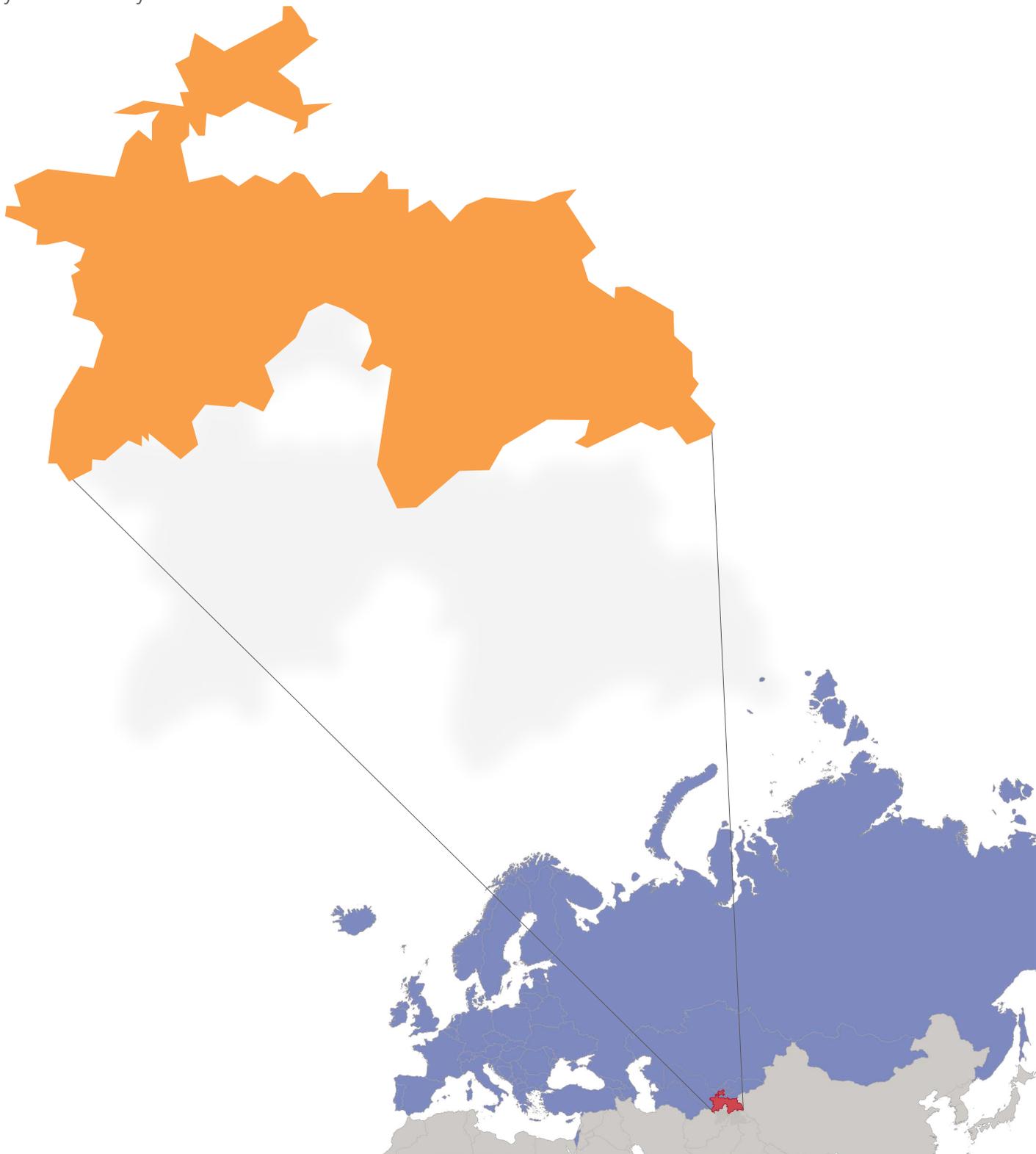
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## TAJIKISTAN

In the last 10 years, the situation surrounding sexuality education has changed significantly in Tajikistan. With the assistance of international organisations, steps have been taken towards introducing healthy-lifestyle education into schools and improving youth-friendly services.





Tajikistan

### Laws and policies on school sexuality education

A number of laws in Tajikistan recognise the right to education and access to SRH services for young people. The Law on Reproductive Health and Reproductive Rights (2002)<sup>1</sup> ensures the right of young people to information and reproductive health services. It also stresses that this information should be provided by trained personnel through age-appropriate programmes. It foresees that these programmes should be delivered through the public education system and health facilities. This law was amended in 2015, and the revised version defines sexuality education for youth much more clearly. The law defines it as a state-controlled task and stipulates that educational programmes should be developed to take societal moral and cultural values into account and be implemented by educational and health institutions. These modifications also provide space for the introduction of a stand-alone course on sexuality education in secondary schools or extracurricular seminars.

In addition, The National Strategy for Education Development 2012–2020 defines the development of ‘skills for healthy lifestyle’ as one of the objectives for school pupils. The Strategic Plan Concerning Reproductive Health of the Population until 2014<sup>2</sup> identified the need of adolescents for information and education for developing respective life skills, reducing STIs and unintended pregnancies, and ensuring access to youth-friendly services. Other important documents that create a legislative framework for implementation of the subject are the Law on Education (2013) and the National Healthy Lifestyle Programme 2011–2020.

According to the resolution of the Government on 28 November 2015, ‘On Provision of Medical Services and Counselling on Reproductive Health to Adolescents, Including Those from Risk Groups’, access to sexuality education is guaranteed to all children, adolescents and their parents. Access to sexuality education should be provided by teachers, tutors, mass media, youth, public organisations and medical specialists. This decree defines the age from which sexuality education should be provided – from 10–14 years – and the topics to be included: general health topics, hygiene, HIV; and from 15+ years: STIs, HIV/AIDS (expanded), family planning methods, contraceptives, etc.

### Organisation and implementation of sexuality education

In the previous development programmes in Tajikistan, the subject of ‘Healthy Lifestyle’ (HLSE) focused on the prevention of HIV, STIs and unwanted pregnancies, and some other elements of sexuality education were developed with the support of international partners (UNICEF, UNFPA and GIZ). The partners established a working group under the aegis of the Tajikistan Education Academy (TEA) and later a Resource Center on HLSE was established under TEA to ensure further sustainability of the programme by building national capacities. A curriculum for teachers and textbooks for the pupils on HLSE were developed with the support of international consultants. This subject was approved in 2002, and the programme was piloted in 500 schools between 2008 and 2011. While UNICEF targeted grades 7–9, the GIZ developed similar training curricula for grades 5 and 6 and the UNFPA country office piloted the programme on HLSE for pupils of 10th and 11th grades. In 2012–2017 the UNFPA supported a translation of the 10th–11th-grade textbooks into the Tajik

and Uzbek languages, their publication and the implementation of training in the capital city and in two regional centres.

The subject is being taught within the ‘classroom hours’, 8 hours per year in grades 7 – 11. No separate hours are allocated for SRH topics. However, a number of elements of sexuality education are included: prevention of and attitudes towards STI and HIV/AIDS, protecting the rights of people living with HIV, combating coercion to enter into sexual relations, personal hygiene, anatomy and physiology of the reproductive system, intimate relationships, safe motherhood, etc. The subject is also linked to extracurricular activities involving medical staff from youth-friendly centres.

Recently, by a decree of the Ministry of Education (MoE) of the Republic of Tajikistan, a national working group was established to roll-out the work on HLSE in the regions and to ensure implementation of mentoring activities to sustain the programme. Incorporation of HLSE topics in a more comprehensive way in the curricula of the National Teacher Training Institute is envisaged as well.

### **Barriers to sexuality education**

Despite the positive developments surrounding sexuality education and the introduction of the Healthy Lifestyle subject, opposition concerning sexuality education still exists. The main barriers for the implementation of sexuality education are social and cultural taboos as well as insufficient economic means to implement the programme. UN partners are actively working with the government and development partners to remove those obstacles through advocacy and communication activities. The consolidated work of all development partners with the government is required to come with the best solution for

filling the financial gaps and ensuring the long-term sustainability of HLSE programmes.

### **Sexuality education outside the formal school setting**

Extracurricular education and information are provided by the UNFPA and by the Tajik Family Planning Alliance (TFPA; IPPF affiliate)\* and through the UNFPA-supported Y-PEER network. Y-PEER Tajikistan actively works with young people, NGOs and government partners to promote peer education and to raise the awareness level of young people and pupils. Being registered as a separate NGO, Y-PEER Tajikistan received several grants from the UN, international organisations and the Government of the Republic of Tajikistan (through the Committee of Youth Affairs) to provide peer education on healthy lifestyles. In 2017, Y-PEER established a partnership with Tajik Pedagogical College in Dushanbe, and its trainers conduct regular sessions on peer education, HIV/STIs prevention, SRH and HLSE topics to all students of the college.

### **Youth-friendly SRH services**

A network of 21 medical-counselling centres for young people was established in 12 districts in five regions between 2007 and 2010. The improvement of these services was supported by a number of international organisations and donors. These centres provide a package of three types of services – HIV, STI and reproductive health services – and focuses on young people most at risk. Young people can access some of the services for free, though some services have to be partly paid for, such as treatment of STIs, ultrasound and abortion. 60 % of the country’s young live in rural areas, and for them it is a significant barrier.

\* <http://tfpa.tj/>



## Tajikistan

Emergency contraception is available without prescription. Condoms are sold only in pharmacies. Young people can get the pill, condoms and IUDs free in medical centres. Other methods can be bought in pharmacies. The age of consent for contraception is about 15, but is not legally defined (in general there is no age limit). The age of consent for abortion is 18 years.

### Survey and vital data on young people's SRH

Young people in Tajikistan comprise a considerable part of country's population; thus, Tajikistan is categorised as a young nation with more than 70% of its population under the age of 30.

In 2012, modern methods of contraception were used by 7% of 15–24-year-old women, according to the DHS. The DHS also showed that 9% of the young women aged 15–24 in Tajikistan have a comprehensive knowledge of HIV/AIDS. The data further shows that 28% of the young women know where they can get condoms. Comprehensive knowledge about HIV/AIDS and about where to obtain condoms is higher among women aged 20–24 years than among those aged 15–19. Both indicators are also higher for young women who are married than for those who have never been married. Urban women are more likely to have comprehensive knowledge about HIV/AIDS and also know more often about where to get condoms than rural women. This knowledge

increases with increasing educational level. For example, the proportion of young women with comprehensive knowledge about HIV/AIDS increases from 3% among those with no or only primary education to 24% of those who have attended higher education.

According to the National AIDS Centre, 20–23% of those aged 15–24 years were diagnosed with STIs in 2015.

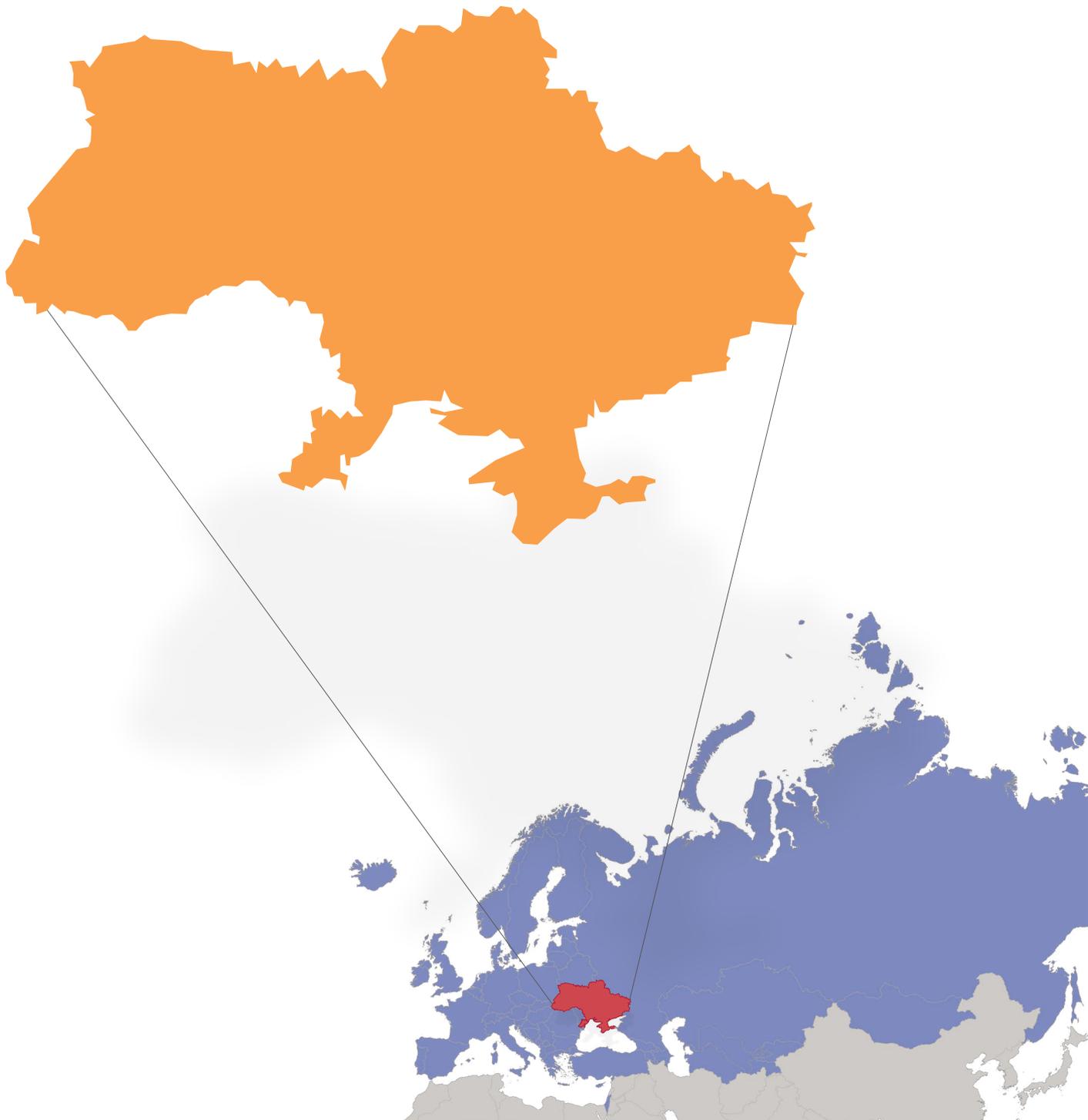
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## UKRAINE

Several elements of sexuality education were introduced in Ukrainian schools as a part of various mandatory and optional subjects, though its delivery may differ across the country and within individual educational institutions. In early 2017, a reform of the education system in Ukraine began which includes a revision of educational programmes and a restructuring of the educational system.





## Laws and policies on school sexuality education

In Ukraine, there is a legal basis supporting sexuality education in schools. A number of state standards were approved by the Cabinet of Ministers of Ukraine – ‘Resolution on Approval of the State Standard of Primary Education’ (2011)<sup>1</sup> and ‘Resolution on Approval of the State Standard of Basic and Complete General Secondary Education’ (2011, last change 2013)<sup>2</sup>, which determine the requirements for the school education.

The state standards contain an educational section entitled ‘Health and Physical Culture’, aimed at developing health competences through acquiring skills for preserving and strengthening health and developing the physical culture of the individual. These are general documents that do not specifically mention topics related to the SRHR of pupils, but they do support the introduction of the health-related subjects in schools as well as the development and the approval of training programmes for this purpose.

In general, the basic educational curriculum is adopted by the Cabinet of Ministers of Ukraine. The Ministry of Education and Science approves all programmes for core academic subjects. All educational institutions, regardless of their affiliation, must adhere to the approved curriculum and programmes. Subjects considered mandatory must be introduced at schools; subjects recommended by the Ministry of Education and Science as elective can be introduced into the school curriculum by the school administration with the involvement of parents. Local (i.e. regional, city and district) administrations and departments of education have the obligation to support and implement educational programmes at the local level.

In early 2017, a reform of the education system in Ukraine began which includes a revision of the educational programmes and a restructuring of the entire educational system. According to the concept of the ‘New Ukrainian School’, approved in December 2016 by the Parliament, schools will have more freedom in creating programmes, though the main idea remains that the programmes have to correspond to state standards. For the first time, beginning in 2017, the educational curriculum revision was conducted publicly through an online platform with the involvement of all interested stakeholders.

## Organisation and implementation of sexuality education

### Responsibilities

Subjects, identified as mandatory, must be introduced in schools. Subjects recommended by the Ministry of Education and Science as elective can be introduced in the school curriculum through the decision of the school administration with the involvement of parents. Local (e.g. regional, city and district) administrations and departments of education have obligations to support and implement educational programmes at the local level.

### Sexuality education in practice

Sexuality education topics are integrated into different mandatory subjects in primary (1–4 grades) and secondary (basic grades 5–9 and comprehensive grades 10–11) schools. Mainly SRHR topics are delivered within mandatory subjects – Basics of Health (grades 1–9, age 6–15 years) and Biology (grade 8, age 13–14 years). Some elements are also covered under Basics of Law (grade 9, age 14–15 years), Ethics (grades 5–6, age 9–10 years) and Physical Culture.

Additional elective subjects and lessons, which include some SRHR topics, can be introduced by the schools themselves. Programmes for such lessons were developed within the framework of the activities of national or international organisations and, after a review, have been recommended for use in schools. Among them are the following:

- ‘Useful Habits’ (grades 1–4)
- ‘Interesting About Useful’ (grades 1–4)
- ‘I Am – My Health – My Life’ (grades 5–6)
- ‘Frank Conversation’ (grades 7–8)
- ‘School Against AIDS’ (grades 8–9)

- ‘Protect Yourself from HIV’ (grades 10–11)

- ‘Grow up Healthy’ (grades 9–11)

It is difficult to determine the exact number of hours pertaining to sexuality education in schools. For example, the subject Basics of Health is designed to encompass 45 academic hours per year, but topics related to different aspects of sexuality education are integrated into the overall programme of this subject. Discussion of different topics occurs according to a spiral principle from year to year, with in-depth attention to SRHR issues provided in grades 8–9.

The WHO/BZgA *Standards of Sexuality Education in Europe* (2010) were presented and discussed with leading educational and medical experts; however, they were not adopted as a platform

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth		X	
Contraception (including at least three effective methods)		X	
HIV/AIDS	X		
STIs	X		
Love, marriage, partnership	X		
Sexual pleasure			X
Sexual orientation			X
Gender roles		X	
Online media and sexuality		X	
Access to safe abortion in the framework of the national law			X
Mutual consent to sexual activity		X	
Sexual abuse/violence		X	
Domestic violence		X	
Human rights and sexuality			X



for joint action. Rather, the *Standards* are used informally to demonstrate the multifaceted nature of topics that are covered by sexuality education. This document is used by some teachers and representatives of NGOs.

Sexuality education in schools is linked to information on access to services and contains information on HIV testing and medical consultation. There are 150 youth-friendly clinics in Ukraine. However, the connection between schools and youth-friendly clinics is not sufficient, which is rooted in the overall poor interaction between institutions.

Differences in the delivery of sexuality education exist throughout the country. Despite the mandatory nature of some subjects, there is evidence of incomplete exposure to some topics. Such differences are due to several causes, including personal rejection of the sensitive topic by the teacher, lack of skills to address different topics and the influence of the local religious community.

Parents are partially involved in sexuality education in schools. The topics of sexuality education are included in the compulsory educational plan for working with parents. The degree of involvement of parents depends on the readiness of the educational institution and the parents themselves. In 2013, the Women's Health and Family Planning Foundation (IPPF member association) developed a package for working with parents, which was approved by the Ministry of Education and Science in 2015; many teachers have been trained to use this technique.

NGOs can be invited to conduct additional educational activities in agreement with the school administration.

## Teacher training

Most teachers in secondary school are trained to teach the Basics of Health subject, which includes SRH issues. Most of them were trained to teach the subject as a second specialty (in addition to their core subject, for example, biology or physics). Additional courses for teachers are organised mostly in the framework of HIV prevention. However, there is a gap in the training of Basics of Health teachers for primary school. Since 2007, only a few pedagogical universities (Kyiv, Lugansk, Kharkiv and Poltava) have offered training for teachers of Basics of Health as a separate specialty.

The Ministry of Education and Science approves the recommendations and materials for teachers for use in schools. Representatives of different organisations (e.g. Academy of Pedagogical Sciences, Institutes/Academies of Postgraduate Teacher Education, Departments of Pedagogical Universities, NGOs and international organisations) are developing such materials. Most of the methodological materials provided include participatory learning approaches, but they do not entirely reflect a comprehensive approach to teaching sexuality education. However, some teachers report the need for more educational materials of good quality.

## Monitoring and evaluation

The implementation and learning outcomes of the subject Basics of Health are monitored by the Department for Monitoring of Educational Processes of the Institute of Innovative Technologies and Educational Content of the Ministry of Education and Science. It is conducted according to the existing guidelines on monitoring the quality of secondary education for the learning outcomes of pupils in secondary

schools, as approved by the Ministry of Education and Science with order no. 1412 of 10-10-2013<sup>3</sup>. Monitoring is conducted among all pupils of the 5th and 10th grades in all types of educational institutions.

The monitoring of the implementation of Basics of Health lessons was carried out in 2007–2010. The last monitoring of learning outcomes in grade 5 was done in 2013. In addition, in 2016 subject implementation was subjected to an online evaluation (in pilot regions) within the EU Project – Learning to Live Together<sup>4</sup>.

### **Opposition to sexuality education**

Opposition to sexuality education exists mainly from some religious communities or associations. Such associations can act both at the ministerial level as well as oppose the implementation of programmes in a specific region.

### **Sexuality education outside the formal school setting**

Several NGOs provide sexuality education in non-school settings. The Women's Health and Family Planning Foundation implemented a programme on a peer-to-peer basis. It also organises theatres, summer schools, contests and thematic activities for a teenage audience on SRH topics. It co-created the website [teenslive.info](http://teenslive.info) for the teenage target audience and provides complete information on SRHR topics, including access to services. The site provides a possibility to put questions to the specialist. A website page is also supported in the social networks.

The Youth Association TEENERGIZER delivers sessions for young people on topics related to HIV prevention. It has a website [TEENERGIZER.ORG.UA](http://TEENERGIZER.ORG.UA) which focuses on HIV prevention and fighting discrimination.

Local TV and radio companies sometimes broadcast series of thematic episodes with the participation of medical staff and representatives of NGOs working in the field of SRHR.

### **Vulnerable groups and special services**

Most of the existing initiatives that provide sexuality education to young people at risk are part of a comprehensive prevention programme aimed at reducing HIV incidence. They are implemented with the assistance of the state and the support of international organisations, mostly at the local level. Some models of the provision of services to young people at risk in Ukraine are described in a UNICEF publication<sup>5</sup>.

### **Good practices and initiatives**

The 'Right to Love' programme was developed for young people (18+ years) with learning disabilities. The programme was created by the Women's Health and Family Planning Foundation in cooperation with the Ukrainian NGO 'Coalition for the Protection of the Rights of Persons with Intellectual Disabilities'. This is a comprehensive programme on sexuality education and has been implemented throughout Ukraine.



## Challenges and recommendations

The respondents provided many recommendations and future steps to ensure the support and delivery of sexuality education in Ukraine:

- improve the training of Basics of Health teachers both for primary and secondary school, including e-learning approaches;
- review the state educational standards as well as the programmes and educational materials of Basics of Health with regard to expanding topics of positive aspects of sexuality, gender equality, sexual and reproductive rights of young people, etc.;
- improve the system of M&E of the Basics of Health lessons, which should ideally be conducted by external organisations/institutes. The monitoring should aim not only to evaluate pupils' level of knowledge, but also to evaluate changes in their attitudes, skills and behaviours;
- strengthen the links between educational institutions and youth-friendly clinics and raise awareness about existing services.

## Youth-friendly SRH services

There is a network of about 150 youth-friendly clinics (YFCs). Services within this network are provided separately for youth. YFCs are located mostly next to children's hospitals, with a separate entrance. They are governmental institutions. However, their number is considered to be not sufficient, and the opening hours of these clinics do not meet the needs of youth, which constitutes a barrier to obtaining SRH services as well.

The main services provided at YFCs are counselling (including pre/post HIV testing), gynaecological examination and diagnosis. Gynaecological examinations and consultation are provided free of charge. The diagnosis and treatment of STIs at YFCs are not offered everywhere and depend on the equipment of the clinic. Services for antenatal care and safe abortion are not provided in the YFCs, but they can be obtained from the Family Planning Centres or women's consultations. Treatment of HIV is also not provided by YFCs, but in case of a positive result for HIV, young persons are redirected to appropriate special institutions and/or doctors. YFCs also deliver single sessions to adolescents on different SRH topics and run their pages in social networks.

Young people must pay for all contraceptive methods, and almost all types are available in Ukraine. Emergency contraception is available without a doctor's prescription from pharmacies. Condoms can be bought in pharmacies and other public places. They are also provided for free at some YFCs and at NGOs working in the field of HIV prevention. Nevertheless, the cost of contraceptives can be a barrier for many young people.

The age of consent for abortion and contraception is 14 in Ukraine. According to Article 284 of the Civil Code of Ukraine, citizens who have reached the age of 14 have the right to independently seek medical help.

## Some survey and vital data on young people's SRH

According to the results of an online survey conducted by the Women's Health and Family Planning in 2016–2017, actual and the preferred sources of information about sexuality and related issues among young people 15–30 years old<sup>6</sup> were as follows:

Sources of information	Actual	Preferred
Parents	24.5 %	11 %
School/teachers	33 %	35 %
Friends/peers	42.5 %	11.8 %
Radio/TV	54.3 %	32.7 %
Internet/social media	87.4 %	30.6 %
Medical workers	26.1 %	48.2 %
NGO	22 %	47.8 %
Older brother/sister	6.9 %	3.7 %
Other relatives	3.7 %	3.7 %
Partner	26.9 %	13.9 %
Health centres, information/consultation centres	6.9 %	44.1 %

\* multiple options were possible

There is a downward trend in the proportion of young people in the age group 15–24 among all newly registered HIV cases (from 12.0 % in 2009 to 5.2 % in 2016) and in the incidence of HIV infection in this age group (from 35.5 per 100 000 in 2009 to 19.4 in 2016)<sup>7</sup>.



Ukraine

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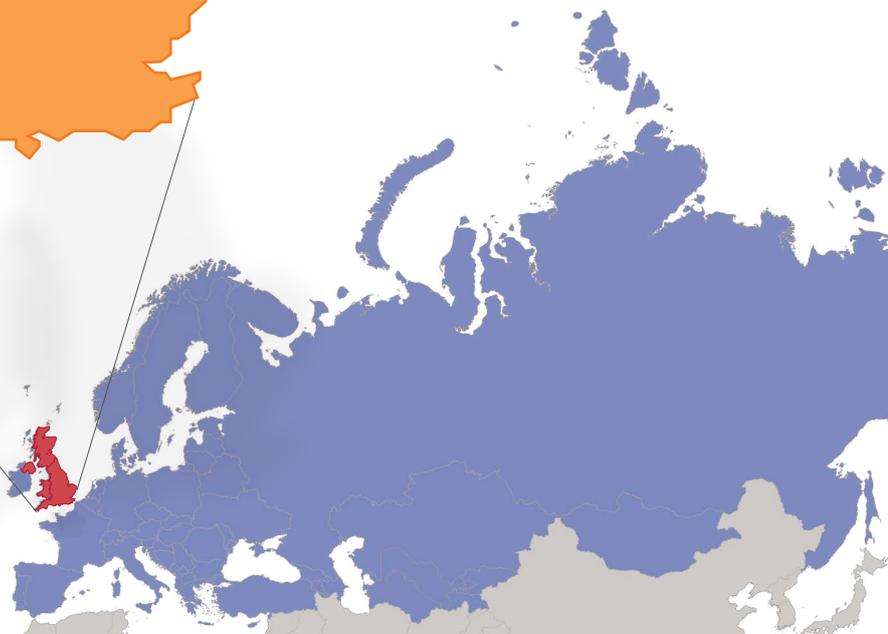
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## THE UNITED KINGDOM (England)\*

Since 1996 'sex and relationship education (SRE)' has been compulsory in public (local authority-run) schools in the United Kingdom (UK), but not in private schools. SRE is integrated into other subjects and mainly taught in science and personal, social, health and economic (PSHE) classes. It focuses mostly on the prevention of unwanted pregnancy and STIs/HIV. In 2017, after persistent pleas by many organisations, the government decided to make sexuality education 'statutory', and as a result it will become mandatory in all schools in 2019.



\*The questionnaire referred only to 'England', and not the United Kingdom, and was filled in as such. However, most, but not all, the information presented also applies to the other parts of the United Kingdom.





The United Kingdom

## Laws and policies on school sexuality education

The Education Act of 1996 provides that some SRE is compulsory for public (local authority-run) schools (not in private schools), from the age of 11 years onwards. A national curriculum sets out the programmes of study and targets for all subjects. All local authority-maintained (i.e. public) schools in the United Kingdom must teach it. However, this does not mean that all publicly funded schools have to teach sexuality education. Some types of schools (academies and free schools) are not required to follow the national curriculum, although it is expected to be used as a guide.

Biological aspects are taught in science classes, other aspects mainly in PSHE classes. In the year 2000, the Department for Education and Employment (now the Department for Education) published a 'Guidance' on the delivery of SRE through the PSHE framework. This Guidance states that 'sex and relationship education should be firmly rooted in the framework for PSHE'. It aims to help schools to plan SRE policy and practice and includes teaching strategies, working with parents and confidentiality. There is no true national SRE curriculum; privately run schools can decide not to adopt the curriculum. Because some academies and free schools are faith-based (and in some cases have entry requirements that reflect this), there may be more opposition there to SRE. Children who are educated at home also do not have to be taught the national curriculum. Where schools are managed by local authorities, however, the latter has a general oversight role for standards in the school, including curriculum teaching. Yet it is still possible to opt out of SRE classes, meaning that parents have the right to withdraw their children from SRE where the lessons concerned do not form part of the national curriculum.

Although there is a requirement that schools maintained by local authorities in the United Kingdom must teach SRE, the requirements are not comprehensive. There has been no change to comprehensive sexuality education since the publication of the Guidance in 2000. However, the FPA (Family Planning Association; national IPPF member) has used the WHO/BZgA *Standards for Sexuality Education in Europe* (2010) when advocating for comprehensive education with statutory status. On March 1, 2017, the government decided that sexuality education will indeed become 'statutory', which means it has to be taught in all schools in the country from 2019 onwards.

Although SRE is not monitored at a national level, according to the Guidance, all schools must have an up-to-date policy that is made available for inspection and to parents. This policy must:

- define sexuality and relationship education;
- describe how sexuality and relationship education is being provided;
- say how sexuality and relationship education is being monitored and evaluated;
- include information about parents' right to withdrawal; and
- be reviewed regularly.

The government Guidance recommends that 'Governing bodies and head teachers should consult parents in developing their sex and relationship education policy to ensure that they develop policies which reflect parents' wishes and the culture of the community they serve'.

## Organisation and implementation of sexuality education

### Responsibilities

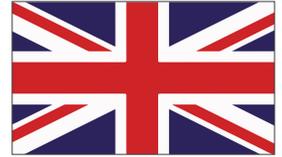
In the United Kingdom, the Department for Education is responsible for the strategic management of the national curriculum, which is taught to pupils from about 12–16 years. Schools are primarily responsible for translating the curriculum into concrete lessons plans. In addition, religious organisations can have input in the curriculum where the school is managed by such a religious organisation. NGOs can also have an input. For example, the PSHE Association has a suggested study programme. The government is supportive of this suggested programme of study for PSHE.

### Sexuality education in practice

Because in practice the schools are rather free to decide on the topics to be included, it is not possible to determine at the national level which topics are being addressed or how extensively they are being dealt with. The experience of FPA reveals that the topics dealt with usually look like described in the table.

In other words, for those schools that follow the 2000 Guidance, the focus tends to be on physical aspects and the prevention of pregnancy and STIs/HIV. But schools may also choose to teach only STI and HIV prevention (i.e. the minimum requirement). It is also up to the schools to decide whether to link the SRE programme to the SRH service delivery for young people. The government issued a non-statutory advice on specific topics, as

Main topics dealt with	How extensive?		
	Extensive	Briefly	Not
Biological aspects and body awareness	X		
Pregnancy and birth		X	
Contraception (including at least three effective methods)	X		
HIV/AIDS	X		
STIs	X		
Love, marriage, partnership		X	
Sexual pleasure			X
Sexual orientation			X
Gender roles			X
Online media and sexuality			X
Access to safe abortion in the framework of the national law		X	
Mutual consent to sexual activity			X
Sexual abuse/violence			X
Domestic violence			X
Human rights and sexuality			X



The United Kingdom

did a range of NGOs. But schools decide on using those, too. Because these are varied and their use is not systematically monitored, it is impossible to assess the extent to which they reflect a comprehensive approach to sexuality education. Schools are advised to engage closely with parents when developing their curriculum.

It is not required that young people be taught about local services or access, although it is assumed that educational facilities will help them to understand their options. The 2000 Guidance states that sexuality education should 'enable [pupils] to become effective users of services that help prevent/treat STIs and HIV'.

### Teacher training

Schools are responsible for ensuring that their teachers are appropriately prepared to deliver SRE. There is no national teacher-training programme for this, but there are a number of interested NGOs, many of whom provide information, resources and training for teachers. Educational materials are often developed by NGOs, including the Family Planning Association, BISH and Brook. Durex (a condom manufacturer) has also convened an expert advisory group to produce resources for teachers<sup>1</sup>. Although some materials are free, some require schools to purchase them. The Department for Education has also endorsed supplementary guidance produced by Brook, the Sex Education Forum and the PSHE Association. All these materials reflect a comprehensive view and participatory teaching approaches.

Some NGOs, such as the young people's charity 'Brook', provide lessons in schools. 'Sexpression' provides close-in-age peer mentoring and lessons. Other charities, including the FPA, provide training for teachers, youth workers and other

professionals. The FPA also produces resources for school leaders, teachers and other professionals.

### Monitoring and evaluation

As mentioned before, there is no specific national SRE monitoring system. The inspectorate, Ofsted, monitors school performance across a range of measures. They take an interest in the delivery of any and all statutory requirements, including the SRE curriculum. SRE outcomes and impact have been evaluated in countless studies.

### Sexuality education outside the regular school setting

Working with the National Youth Agency, the FPA delivers a course for youth workers which covers information on contraception and STIs as well as building an understanding of the law. Up to 2011, TV Channel 4 broadcasted a sexuality-education programme with episodes that are still available online<sup>2</sup>. The FPA and BISH provide online resources about sex and relationships<sup>3</sup>.

The FPA works directly with people with learning disabilities in schools and other settings. Its project in the London Borough of Westminster offers SRE and training to people with learning disabilities from age 14 on, their support staff and their parents and carers at schools, colleges, day centres and homes.

### Opposition to sexuality education

There is no significant opposition to sexuality education in the United Kingdom. In fact, the reverse is true. The statutory status for a comprehensive sexuality-education programme had the support of five Parliamentary select committees, the Children's Commissioner,

the Chief Medical Officer, the Association for Directors of Public Health, the Association of Police and Crime Commissioners, the Association of Independent Local Safeguarding Children Boards Chairs, two royal societies, five leading unions, six medical royal colleges and over 100 expert bodies (according to the PSHE Association). Nevertheless, the Government had always been quite reluctant to introduce comprehensive sexuality education in schools.

### Challenges and recommendations

According to the FPA, the following recommendations are still relevant:

1. Make a comprehensive programme of sexuality education statutory, as a part of (PSHE) curriculum. (This was finally adopted on 1 March 2017.)
2. Update the government's guidance on sexuality education written in 2000 to reflect changes in technology.
3. Ensure that sexuality education is open and inclusive of all children and young people, recognises and meets the needs of young people of different gender identities, sexual orientations, minority ethnic groups and those with physical or learning disabilities.
4. Improve sexuality-education teacher training and include it as part of initial teacher training.

### Youth-friendly SRH services

The young people's charity 'Brook' runs clinics around the UK, offering free and confidential sexual health advice and contraception to people under 25 years of age<sup>4</sup>. These clinics are separate from other health services, but are sometimes organised

in partnership with private providers (such as Virgin Care). Their services are commissioned by local authorities. All SRH services for young people, including contraceptives, are free of charge. Emergency contraception is available from pharmacies without a prescription. Such services at community pharmacies are commissioned through local councils and quite often come with age restrictions for free emergency contraception (for example, in some areas payment is required for those over 25 years old). Condoms are for sale in supermarkets and other outlets.

Laws relating to the consent of young people in respect of SRH services are not legislatively mandated, but rather to be found in common law. In 2004, the Department of Health released revised guidelines for health professionals in the United Kingdom. These guidelines state that sexual-health services should be provided under a policy of strict confidentiality for individuals under the age of 16. In order to determine whether an individual under the age of 16 is competent to give informed consent to a medical procedure or treatment, the individual is assessed under the so-called 'Fraser Guidelines'. Pursuant to these guidelines, a doctor is permitted to give advice and treatment after having checked a patient's decision-making competency and some other issues.

### Data derived from surveys

In 2015, 62% of the heterosexuals aged 15–24 years diagnosed in sexual-health clinics were infected with chlamydia, 52% with gonorrhoea, 51% with genital warts and 41% with genital herpes.

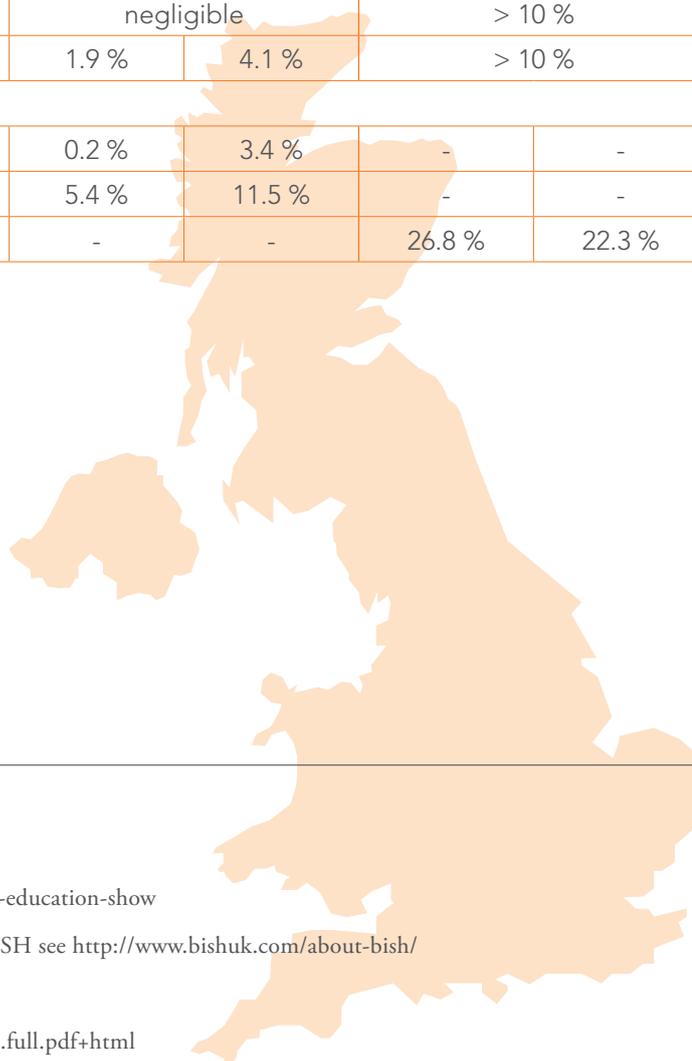


The United Kingdom

### Survey data 2010 - 2012: actual and preferred sources of information (people aged 16 - 24 years)

Sources of information	Main sources		Ought to have known more from; according to young people	
	Female	Male	Female	Male
Mother	13.5 %	4.3 %	40 %	14.6 %
Father	2.8 %	0.5 %	-	22.7 %
School/teachers	41.3 %	39.4 %	47.7 %	
Friends/peers	24.1 %	24.1 %	> 10 %	
Radio/TV	29 %	20.1 %	> 10 %	
Magazines/books	negligible		> 10 %	
Internet/social media	1.9 %	4.1 %	> 10 %	
<b>Other</b>				
Pornography	0.2 %	3.4 %	-	-
First sexual partner	5.4 %	11.5 %	-	-
Health professionals	-	-	26.8 %	22.3 %

Source: Reference 5



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- 1 See: <http://www.dosreforschools.com/>
- 2 See <http://www.channel4.com/programmes/the-sex-education-show>
- 3 FPA see <http://www.fpa.org.uk/help-and-advice>; BISH see <http://www.bishuk.com/about-bish/>
- 4 See <https://www.brook.org.uk/>
- 5 See <http://bmjopen.bmj.com/content/5/3/e007834.full.pdf+html>

# 5 The Way Forward

# The Way Forward

## Conclusions and Recommendations

# Conclusions

**Main conclusion 1:** Since 2000, rapid progress has been made in developing and integrating sexuality education into formal school settings in the European Region.

- In 15 of the 25 countries included in this survey, which is fairly representative for the region, a legal basis for teaching sexuality education in schools was either recently created or adopted. In half of the remaining countries meaningful initiatives are currently taking place to develop sexuality education in the school.
- In 10 of the 25 countries in this assessment, the sexuality-education programme has a clear comprehensive character, and in 4 more countries the programme is becoming more comprehensive. In the remaining countries, sexuality education either hardly exists or is focused primarily on biological aspects.

**Main conclusion 2:** Although sexuality education in this region varies greatly, it also has many remarkably common characteristics.

- Sexuality education in the European Region is almost always integrated into wider teaching subjects, like biology, life skills or health education; stand-alone programmes are rare.
- In descending order, topics in sexuality education that are most often addressed are those related to the biology of the human reproductive system; prevention of HIV/STIs; pregnancy and birth; and contraception. Some attention is also paid to love, marriage and partnership; gender roles; mutual consent to sexual contacts; sexuality and online media; and human rights and sexuality. Only sporadically are access to abortion, sexual abuse, domestic violence, and particularly sexual pleasure addressed.
- In 11 of the 25 countries, the school sexuality-education programme is mandatory; in seven countries it is partly mandatory, i.e. not in all schools; and in only four it is optional.

**Main conclusion 3:** School-based sexuality-education programmes exist in a social context where related initiatives are also being implemented and where opposition may occur.

- In about half of the countries in the European Region, there is still serious opposition to sexuality education. The main argument against it – ‘it will encourage young people to start early with sexual relationships’ – is not supported by the results of international research. On the contrary, in countries with well-developed sexuality education, young people tend to start later with sexual contacts.
- In all countries of the European Region activities are being implemented to teach young people out of school about sexuality-related issues. These activities target mostly vulnerable, marginalised and high-risk young people. In several countries, these groups are reached by means of peer education.
- In about 80% of countries in the European Region, special youth-friendly SRH service centres or clinics are available, although in several countries their number is insufficient to meet the needs of all young people. However, in countries where these special services are not available, adolescent sexual health is in general not worse. In some countries, the reason for this seems to be that adult services are sufficiently accessible and acceptable for young people.

**Main conclusion 4:** Comprehensive sexuality-education programmes correlate with positive adolescent SRH indicators. Nevertheless, other influencing or intermediate factors may be responsible for such correlations.

- Since the year 2000, the teenage birth rates in all except one country in the region have shown a declining trend, particularly in countries where those rates were already low. Where they were high, they tend to remain (quite) high. As a result, there are now huge differences in teenage birth rates throughout the region, varying between a low 3 per 1 000 15–19-year-old girls in Switzerland and a high of 39 per 1 000 in Kyrgyzstan.
- In countries with fully developed comprehensive sexuality-education programmes, young people tend to mention particularly the school as an important source of information about sexuality, and teenage birth rates tend to be very low. Conversely, teenage birth rates tend to be very high in countries where sexuality education is virtually absent from the schools.
- In countries where sexuality education is hardly or not taught in schools, teenage birth rates tend to be high. In those countries, use of reliable contraceptive methods by sexually active young people tends to be low.
- One in five young people in the region have had sexual intercourse before or at age 15. While there are certain differences among the countries, the variation in this percentage across the region is not huge: the lowest percentage is found in Switzerland and the Netherlands (15%) and the highest in Bulgaria (30%).

# Recommendations

**Main recommendation 1:** Knowledge and experience in developing and implementing school-based sexuality-education programmes in European countries should be much more shared internationally.

- The extent of knowledge and practical experience with sexuality education in many countries of the European Region is much greater than in other regions of the world, though this is hardly reflected in the international literature. Therefore, more studies from this region on the subject of sexuality education should be initiated and published in international journals and shared with international expert organisations working in this field.
- Direct sharing of knowledge and experience and collaboration in the field of sexuality education should be strengthened at the European level. Several countries in Europe have useful experiences, and there are new and innovative initiatives on how to develop and run sexuality-education programmes throughout the entire European Region. These experiences should be shared with countries that are just starting to develop sexuality education or would like to improve their programmes. Furthermore, internationally agreed upon strategies and action plans, such as the WHO Action Plan for SRHR, can provide an additional and useful basis for the development of policies and programmes.
- European countries that do not yet have a legal basis for sexuality education should be supported in creating such a basis, using the examples of other, comparable European countries with a sound legal basis. The new WHO Europe Action Plan on Sexual and Reproductive Health is a useful basis for this and for the development of policies and programmes in the field of SRH in general (World Health Organization; Regional Office for Europe, 2016b).
- Scientific evidence of the positive impact of sexuality education on young people's health and well-being and of the conditions that contribute to positive impact is widely available (UNESCO, 2009 & 2017). However, far less is known about how sexuality education is perceived and appreciated by pupils. For this reason, there is a need for a shift of attention in evaluation studies (Ketting et al. 2016). Core questions that should be addressed in evaluation research are: Does sexuality education really respond to the needs and interests of pupils, and what do they miss? Do they feel the teaching is comprehensible, useful and applicable in their personal lives? Which teaching methods are most appreciated by pupils? Do pupils feel they are sufficiently involved in the teaching process? It is also essential that young people be much more involved in the development, implementation and evaluation of sexuality education programmes.

**Main recommendation 2:** The quality of sexuality-education programmes needs to be improved by starting sexuality education in pupils of a young age, increasing their involvement in it, broadening the range of topics addressed and improving teacher training and support.

- In several European countries, sexuality education starts in primary (or elementary) school, where it tends to focus on knowledge of the human body, its functions and changes during puberty as well as on human relationships. It is essential that this education be taught at a relatively young age, and that it precede education on having sexual contacts and issues directly related to this (i.e. contraception or the prevention of STIs).
- This report clearly shows that young people themselves want and appreciate school sexuality education. They should also become much more involved in developing, implementing and evaluating such programmes. In the end, they are the ones who stand to benefit most from them, and that is best guaranteed if the programmes reflect and respond to their needs.
- Because several sexuality-education programmes still tend to focus primarily, or almost exclusively, on the biological aspects of reproduction and prevention of HIV/STIs and unwanted pregnancy, there is a need to broaden the spectrum of topics that are addressed. Important other topics that should also be dealt with are gender equity, mutual consent to sexual contacts, sexuality on the internet and social media, human rights and sexuality, and particularly access to abortion, sexual abuse, and sexual pleasure.
- In the majority of countries in the European Region there is a clear need to train teachers to teach sexuality education, and there is a great need to develop the appropriate educational materials for that purpose. Only in a handful of countries throughout the region has the training of future teachers on sexuality education been included in the training curricula of teacher training colleges and universities. The same should now be done in all other countries where sexuality education is mandatory or optional. The WHO/BZgA *Standards for Sexuality Education in Europe* (2010) and the publication *Training Matters: A Framework for Core Competencies of Sexuality Educators* (BZgA, 2017) can be useful for this purpose.

## Recommendations

**Main recommendation 3:** Young people both in and out of school should receive more support in their development to adulthood and should have access to SRH services that respond to their needs. The benefits, and especially the absence of any negative impact, of sexuality education should be effectively explained to all stakeholders. The implementation of sexuality programmes should be monitored and evaluated in a more holistic manner.

- Throughout the European Region young people tend to start sexual relations at the age of 16–18 years, while they tend to marry or cohabit about 10 years later. During that 10-year period, they should be enabled to preserve their sexual health – for which sexuality education is indispensable if they are to build happy and healthy relationships based on gender equity, mutual consent, prevention of sexual ill-health and freedom from sexual and domestic violence.
- Young people who do not yet get sexuality education in school should be educated in extracurricular efforts that are especially directed toward them because they are often most at risk of sexual-related diseases, sexual abuse, bullying and sexual harassment. This concerns, among others, children and young people who are homeless, living in correctional institutions and orphanages, and those with physical or intellectual disabilities. This report provides a wide variety of examples of such educational efforts. Recently, a training guide was also published on how to approach and work with these most-at-risk adolescents (MARA, see UNFPA EECARO 2015).
- Sexuality education should always be complemented by SRH service delivery for young people. Those services should be ‘youth-friendly’, which means that they are responsive to the SRH needs of young people, and that they are easily accessible, free of charge (or at least subsidised), anonymous and confidential. This can be accomplished by making general SRH services generally more youth-friendly, or by creating special services for young people, depending on the conditions in the country. A close collaboration between those services and sexuality education at school is beneficial.
- Sexuality education in schools complements the efforts of parents and creates a protective environment for all young people. It fills a gap if parents are absent, do not feel competent or are unable or unwilling to provide the life skills and knowledge to protect young people’s SRH and rights and to foster healthier social and emotional relations. In many countries, there are best practices available to help parents to build their competence and to speak easily and openly about sexuality issues and thus to increase their emotional competence. There are also best practices present for promoting the involvement of parents and enhancing their understanding of sexuality education.
- Because there still is widespread misunderstanding about the impact and benefits of sexuality education, there is a strong need to explain the results of scientific research in this field to decision-makers, the educational sector and the public at large. Scientific evidence is available, but this evidence should be made

easily accessible and comprehensible for those who are not used to reading scientific reports. The BZgA and UNFPA series of 'Policy Briefs' can play an important role in this respect (see references to Policy Briefs in the Annexe).

- M&E of sexuality education should be strengthened and should focus on the relevance of such teaching for pupils. Apart from measuring outcomes or learner appreciation, M&E should also focus on the quality of the sexuality-education programme (i.e. the degree of comprehensiveness and active involvement of pupils) as well as on the quality of implementation of the programme.

# 6

Annexe

# Annexe

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\* Country-specific references are given at the end of the respective country profiles in Chapter 4.



# List of Abbreviations

*not including country-specific abbreviations*

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>BZgA</b>	Bundeszentrale für gesundheitliche Aufklärung (Federal Centre for Health Education)
<b>CSE</b>	Comprehensive Sexuality Education (in UK: Child Sexual Exploitation)
<b>CSO</b>	Civil society organisation
<b>DHS</b>	Demographic and Health Survey
<b>EC</b>	Emergency contraception
<b>GIZ</b>	Gesellschaft für internationale Zusammenarbeit
<b>HBSC</b>	Health Behaviour in School-aged Children (WHO Europe survey)
<b>HIV</b>	Human immunodeficiency virus
<b>IPPF EN</b>	International Planned Parenthood Federation, European Network
<b>IUD</b>	Intra-uterine device
<b>LARC</b>	Long-acting reversible contraceptive
<b>LGBTI</b>	Lesbian, gay, bisexual, transsexual, intersexual
<b>M&amp;E</b>	Monitoring and evaluation
<b>NGO</b>	Non-governmental organisation
<b>RSE</b>	Relationships and sexuality education
<b>SAFE (project)</b>	Sexual Awareness for Europe (project)
<b>SRH(R)</b>	Sexual and reproductive health (and rights)
<b>STI</b>	Sexual transmitted infection
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organisation
<b>UNICEF</b>	United Nations Children's Fund
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	World Health Organization

# Glossary

*This glossary was included in the questionnaire used for this report (see questionnaire).*

**Age of consent** – age at which a person is considered legally competent to consent to sexual intercourse (or to marriage, medical care, etc.)

**Comprehensive sexuality education (CSE)** – Comprehensive or holistic sexuality education means ‘learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education starts early in childhood and progresses through adolescence and adulthood. It aims at supporting and protecting sexual development. It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people’s sexual health and well-being.’

**Emergency contraception** – refers to methods of contraception that can be used to prevent pregnancy in the first 5 days after sexual intercourse. It is intended for use only following unprotected intercourse, misuse of contraception (such as forgotten pills, or breakage or slippage of condoms), rape or coerced unprotected sex.

## **Formal and non-formal learning/settings**

– Formal learning occurs in an educational or training institution and is structured in terms of learning objectives, learning time/support. It can, but does not necessarily have to, lead to a recognised qualification. Non-formal learning is an extracurricular educational activity based on voluntary participation.

**Learner** – a child or young person who is enrolled or attends classes in school including primary (basic/elementary), secondary (middle) and high school.

**Local governments** – an administrative body of a smaller geographic area than the (federal) state, such as a city, town, province/county, or state.

**LARCs** – long acting reversible contraceptives, i.e. methods of birth control that provide effective contraception over an extended period without requiring user action. These include injections, intra-uterine devices (IUDs) and subdermal contraceptive implants.

**Oral contraception** – medication taken by mouth to prevent pregnancy. Also known as birth control pills.

**Participatory learning** – an approach that enables and empowers pupils to share, analyse and enhance their knowledge and to plan, act, monitor, evaluate and reflect. Methods include using small group work to explore scenarios and dilemmas, drama and role play, writing songs or poems, discussions and debates, etc.

**SRH services** – sexual and reproductive health services. According to IPPF’s Integrated Package of Essential Services, the 8 essential SRH services are counselling, contraception, safe abortion care, STIs/RTIs, HIV, gynaecology, prenatal care and counselling after gender-based violence.

**Vulnerable groups** – Vulnerability can encompass three main dimensions:

- socioeconomic deprivation (people living below the national poverty line);
- social exclusion or marginalisation (people who are unable to participate fully in society because of their culture, sexuality, language, religion, gender, education, migrant status, disability or other factors);
- being underserved (people not adequately cared for because of a lack of capacity or political will).

These dimensions are often interlinked, with individuals experiencing several layers of vulnerability

that require tailored advocacy, empowerment and service interventions.

**Youth-friendly services** – These services encourage youth participation in the design, implementation and evaluation, are easily accessible with flexible opening hours, offer a wide range of affordable and high-quality services, are confidential, reach diverse young people in a variety of settings, support service providers and respect the rights of the client.

# Questionnaire



## QUESTIONNAIRE

on

Sexuality Education  
in Europe and Central Asia



Country:  
Name of organisation and department:  
Name of respondent:  
Date completed:

### Instructions

The questionnaire consists of 33 questions. When questions ask for a 'yes' or a 'no', please put a cross in the box of the applicable answer before responding to any follow-up questions. Questions are broadly formulated in order to capture different country situations. We encourage you to use the answer categories 'other' or 'comments' to clarify your answer if needed. The 'comments' boxes can (also) be used to give a written answer if none of the pre-coded answers reflect the situation in your country or if you would like to provide further information that is only relevant for certain groups (for instant certain age groups).

Immediately below we explain some terms used that might be helpful for you when you fill in the questionnaire.

### Glossary

*(included in this report on page 194)*

## Part 1: National laws, policies and standards around sexuality education

If there is *no sexuality education in schools* at all in your country, even not as part of another teaching subject or only in a few schools, you can leave questions 1–20 unanswered.

1. Are there any laws or policies in place *requiring* sexuality education in the formal education system?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	Name of law/policy:
	What are the overall goals of the law or policy?
	Is the law or policy generally supportive or restrictive of <b>comprehensive sexuality education</b> (see Glossary)?
Comments:	

2. Is sexuality education a separate teaching subject or is it integrated in a wider subject (like 'health education' or 'life skills education')?

<b>Separate subject</b> <input type="checkbox"/>	<b>Integrated in wider subject</b> <input type="checkbox"/>
Is it called 'sexuality education' or has it another name? If other name, which one?	What is the name of the wider subject?
Comments:	

3. Do local/regional governments have any responsibility for sexuality education (e.g. for development, delivery, support)?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	Please specify:

4. Is there a national sexuality-education curriculum and/or is there a set of objectives defined?

No <input type="checkbox"/>	Yes <input type="checkbox"/>
	How would you characterise the overall approach:
	<input type="checkbox"/> (Very) comprehensive
	<input type="checkbox"/> Abstinence + prevention of pregnancy and STIs/HIV
	<input type="checkbox"/> Abstinence only
	<input type="checkbox"/> Other: ...
	Have the WHO/BZgA <i>Standards for Sexuality Education in Europe</i> (2010) been used in your country?
	<input type="checkbox"/> Yes, extensively
	<input type="checkbox"/> Yes, only partly
	<input type="checkbox"/> No
	If so, <b>how</b> were the Standards used (e.g. curriculum development, advocacy, etc.)? Please specify:

5. Is sexuality education mandatory? Please put one X in the right-hand column.

Yes, for all students	<input type="checkbox"/>
Yes, but possible to opt out	<input type="checkbox"/>
No, students can choose between sexuality education or other subjects	<input type="checkbox"/>
No, sexuality education is provided after school hours for those who want it	<input type="checkbox"/>
Other, namely: ...	<input type="checkbox"/>
Comments:	

6. Sexuality education is required (roughly) for which age groups of students?  
(put a X after every applicable age group; there can be more than one)

Under 10 years	<input type="checkbox"/>
10–11 years	<input type="checkbox"/>
12–13 years	<input type="checkbox"/>
14–15 years	<input type="checkbox"/>
16 years & older	<input type="checkbox"/>
<b>Total number of teaching hours for entire sexuality education programme</b> (all age groups together) is: ..... <b>hours</b>	
Comments:	

7. Has sexuality education in your country been evaluated (e.g. process, outcome, impact)?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	Please specify and give main results:
Comments:	

## Part 2: Implementation of sexuality education

8. Who is primarily responsible for curriculum development? (e.g. teachers, schools, Ministry of Education, others)

Primary responsibility:

9. Do any of the following persons/groups also have any input into the curriculum? (E.g. through curriculum development working group, advisory board, technical expert groups, review of curriculum, other consultations, public discussions, etc.)

Other involved persons/groups	No	Yes	If yes, describe how they are involved
Teachers/education professionals			
Government representatives			
Young people			
Religious groups			
Healthcare professionals			
Non-governmental organisations			
Others (please indicate):			
Comments:			

10. Please indicate what the major topics in sexuality education are and how extensively they are dealt with. (Put one X in each row; more than one answer possible)

Main topics dealt with	How extensive?			
	Extensive	Briefly	Not	Don't know
Biological aspects and body awareness				
Pregnancy and birth				
Contraception (including at least three effective methods)				
HIV/AIDS				
STIs				
Love, marriage, partnership				
Sexual pleasure				
Sexual orientation				
Gender roles				
Online media and sexuality				
Access to safe abortion in the frame of the national law				
Mutual consent to sexual activity				
Sexual abuse/violence				
Domestic violence				
Human rights and sexuality				
Other 1 (please indicate):				
Other 2 (please indicate):				
Comments:				

11. Is sexuality education linked to information on how/where to access services?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	In which ways?
Comments:	

12. Are teachers usually being specially trained to provide sexuality education?

No <input type="checkbox"/>	Yes <input type="checkbox"/>
	How many teachers have been specially trained?: <input type="checkbox"/> (almost) all of them <input type="checkbox"/> about half of them <input type="checkbox"/> only (very) few of them
	About how long does this teacher training take? <input type="checkbox"/> One day or less <input type="checkbox"/> 2–3 days <input type="checkbox"/> 4 days or more
Comments:	

13. Are educational materials and teaching guidelines available for teachers?

No <input type="checkbox"/>	Yes <input type="checkbox"/>
	Who develops these materials and/or guidelines?
	Do these educational materials reflect a comprehensive approach (see Glossary) to sexuality education?
	Do these teaching guidelines reflect a participatory learning approach to teaching sexuality education?
Comments:	

14. Does provision of sexuality education vary largely across the country (some schools do it quite extensively, other schools hardly or not. Example: only in some private, not in public schools)?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	In which ways mainly?
Comments:	

15. Are parents involved in sexuality education in schools?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	In which ways mainly?
Comments:	

16. Are NGOs involved in sexuality education in schools (e.g. in provision of lessons)?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	In which ways mainly?
Comments:	

17. Is the quality of the delivery of sexuality education in schools monitored or evaluated?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	How? Please describe:
	What are main results?
Comments:	

18. Is sexuality education provided in non-school settings? If no, leave the table below empty. If yes, please complete the below table.

<b>Setting</b>	<b>Which organisation is providing?</b>	<b>Main content:</b>
Youth centers/clubs		
NGOs		
TV/radio		
Online channels		
Other:		
Comments:		

19. Are there programmes (government or non-government) in your country to reach the most vulnerable young people with sexuality education?

No <input type="checkbox"/>	Yes <input type="checkbox"/> For the following groups in particular:	Yes = X
	Young LGBTI people Young injecting drug users Young sex-workers HIV positive young people Roma young people Rural young people Young people out of school Young people living with a physical/intellectual disability Undocumented migrant young people Young people in correctional institutions Other: ...	.... .... .... .... .... .... .... .... .... ....
If yes, please provide a short description (name, aims, content etc.):		

20. Can you share any good practice projects or programmes related to sexuality education from your country?

Good practice projects/programmes:

## Part 3: Opposition and barriers to sexuality education

21. Is there substantial resistance to sexuality education in your country?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	From whom and what are their main arguments against sexuality education?
Comments:	

22. What would be important recommendations and/or needs, if any, from your organisation/government to improve access to and quality of sexuality education in your country?

Recommendations and/or needs:
-------------------------------

## Part 4: Youth-friendly sexual and reproductive health (SRH) services

23. Do youth-friendly SRH services (see Glossary) exist in your country?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/> Please, also answer the questions below.
	Are they available nationally? Please give details:
	Are they integrated in other health services or are they provided separately? Please give details:
	Are they run by the government, private providers or non-governmental organizations? Please describe:
Comments:	

24. Do young people have to pay for SRH services (see Glossary)?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	<p>Please specify which services must be paid for by putting a tick (✓) in the <input type="checkbox"/>:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> STIs/RTIs (testing)</li> <li><input type="checkbox"/> STI (treatment)</li> <li><input type="checkbox"/> HIV (testing)</li> <li><input type="checkbox"/> HIV (treatment)</li> <li><input type="checkbox"/> gynaecological care</li> <li><input type="checkbox"/> prenatal care</li> <li><input type="checkbox"/> contraceptive counselling</li> <li><input type="checkbox"/> counselling after gender-based violence</li> <li><input type="checkbox"/> safe abortion care</li> <li><input type="checkbox"/> Other: .....</li> </ul>
	Are the costs of SRH services a barrier for most young people?
<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	Please specify:
Comments:	

25. Is emergency contraception available from pharmacies without a doctor's prescription?

<b>No</b> <input type="checkbox"/>	<b>Yes</b> <input type="checkbox"/>
	Are there any age restrictions?
Comments:	

26. Are condoms for sale in kiosks, drugstores, supermarkets or any other public places?

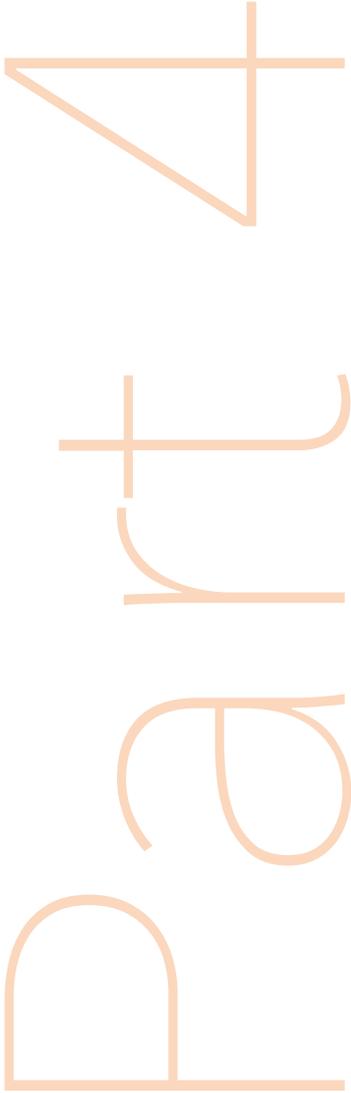
No <input type="checkbox"/>	Yes <input type="checkbox"/>
Comments:	

27. Do young people have to pay for contraceptives?

No <input type="checkbox"/>	Yes <input type="checkbox"/>
	<p>Please specify for which contraceptives: tick (✓) for each method that has to be paid for:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Condoms</li> <li><input type="checkbox"/> Oral contraception (the pill)</li> <li><input type="checkbox"/> Vaginal ring</li> <li><input type="checkbox"/> Contraceptive patch</li> <li><input type="checkbox"/> IUD</li> <li><input type="checkbox"/> Injectables</li> <li><input type="checkbox"/> Implants</li> <li><input type="checkbox"/> Emergency contraception</li> <li><input type="checkbox"/> Other: ....</li> </ul>
	Are the costs of SRH services a barrier for most young people?
No <input type="checkbox"/>	Yes <input type="checkbox"/>
	Please specify:
Comments:	

28. What is the age of consent for contraceptive and for abortion services?

Contraceptive services: ..... years Abortion services: ..... years
Comments:



## Part 5: Some core data on young people's SRHR in your country

If only estimates are available, please fill those in with the remark '(estimate)'

The questions below can only be answered if results of **recent surveys** (2010 or later) among young people are available. If not available, leave these questions unanswered.

29. What are the **actual** and the **preferred** sources of information about sexuality and related issues among young people? Give percentages.

Survey year: 201..			
Age group:			
<b>Actual sources of information of young people</b>	%	<b>Sources of information preferred by young people</b>	%
Parents		Parents	
School/teachers		School/teachers	
Friends/peers		Friends/peers	
Radio/TV		Radio/TV	
Magazines/books		Magazines/books	
Internet/social media		Internet/social media	
Other		Other	
Comments:			

30. What % of young people (< 25 years) at risk of pregnancy use a modern, effective method of contraception (mainly contraceptive pills, IUD or condoms)?

Survey year: 201..	Age group or groups	% sexually active	% use modern contr.
Comments:			

31. What % of young people (< 25 years) has been diagnosed with having an STI?

Survey year: 201..	Age group or groups	% sexually active	% having an STI
Comments:			

32. What % of young people (< 25 years) has been diagnosed with having an HIV infection?

Survey year: 201..	Age group or groups	% sexually active	HIV infected per 100 000 population
Comments:			

33. Please use the below box to share any other relevant data that exists in your country.

**Thank you very much for completing this questionnaire!**

Please return this filled in questionnaire to our researchers:

Evert Ketting: [e.ketting@tip.nl](mailto:e.ketting@tip.nl) and  
Olena Ivanova: [olena.ivano@gmail.com](mailto:olena.ivano@gmail.com)

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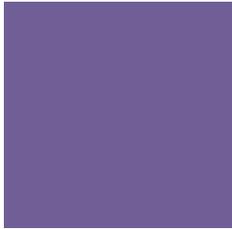
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# FACT SHEETS



## Sexuality Education in the WHO European Region

The fact sheets featuring 25 individual country profiles as well as a regional overview of the situation of sexuality education are based upon a joint research project of the International Planned Parenthood Federation European Network (IPPF EN) and the Federal Centre for Health Education (BZgA), a WHO Collaborating Centre for Sexual and Reproductive Health. The data of this research were collected between October 2016 and July 2017 by means of written expert interviews with representatives of governmental and non-governmental organisations in 25 countries and collection of available data from international information sources.

The fact sheets are available for download:

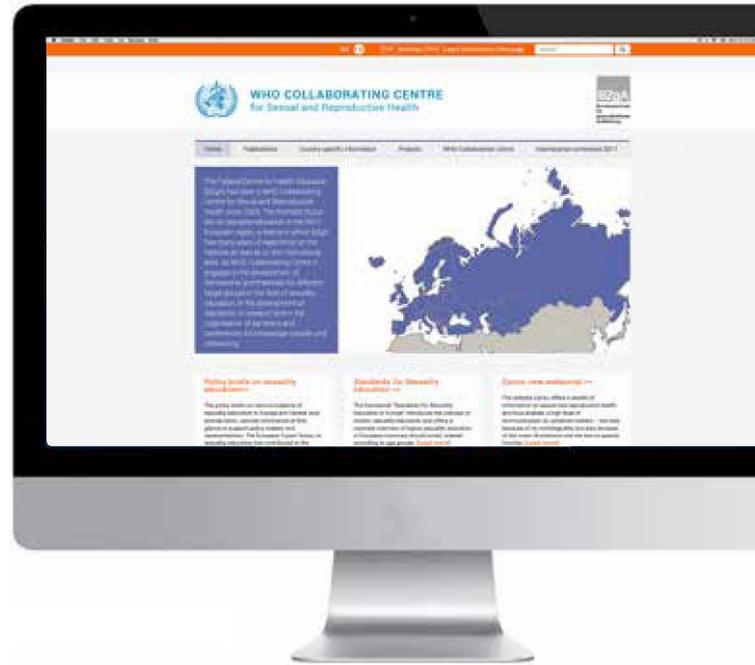
<https://www.bzga-whocc.de/en/publications/>





## ONLINE INFORMATION

The website [www.bzga-whooc.de/en/home](http://www.bzga-whooc.de/en/home) also offers information on the work of BZgA as WHO Collaborating Centre for Sexual and Reproductive Health.



BZgA has been a WHO Collaborating Centre for Sexual and Reproductive Health since 2003. The thematic focus lies on sexuality education in the WHO European region, a theme in which BZgA has many years of experience on the national as well as on the international level. As WHO Collaborating Centre it engages in the development of frameworks and materials for different target groups in the field of sexuality education, in the development of standards, in research and in the organisation of seminars and conferences for knowledge transfer and networking.



## RESEARCH ONLINE

The website [www.english.forschung.sexualaufklaerung.de](http://www.english.forschung.sexualaufklaerung.de) provides quick access to current and past BZgA research projects. For every project, there is an overview, an abstract, selected results and further information.





# INTERNATIONAL CONFERENCE

## **Sexuality education: lessons learned and future developments in the WHO European Region**

International conference in Berlin  
Humbolt Carré  
15 & 16 May 2017

Over 180 experts on sexual and reproductive health and sexuality education from more than 30 countries throughout the WHO European Region attended the conference in Berlin in May 2017.

The overall aim of the conference was to promote sexuality education as an integral part of health promotion and as a crucial element in supporting the healthy development of children and young people. The conference also provided a platform for the facilitation of:

- scientific and technical exchange on latest research results and examples of good practice; and
- networking opportunities among international experts working in the field of sexuality education.

Specific objectives of the conference were to:

- provide an overview on trends and the current state of sexuality education in the WHO European Region; and
- identify current challenges related to the implementation and improvement of sexuality education, as well as future strategies and approaches to address them.

The conference documentation is also available for download:

<https://www.bzga-whocc.de/en/international-conference-17/>





# STANDARDS FOR SEXUALITY EDUCATION IN EUROPE

## **A framework for policy makers, educational and health authorities and specialists**

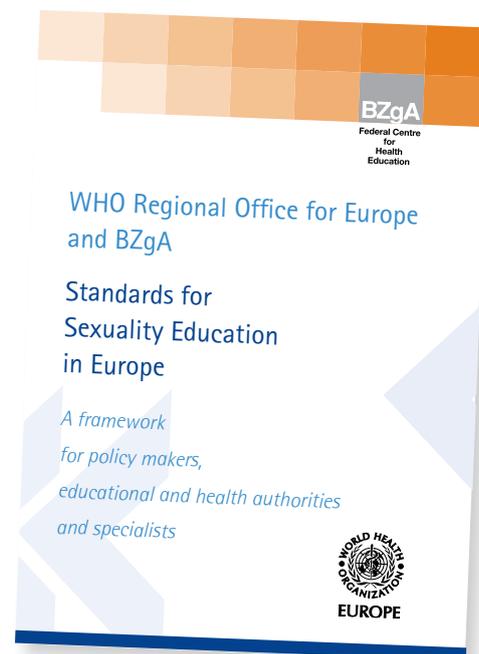
In their jointly developed framework *Standards for Sexuality Education in Europe*, the WHO Regional Office for Europe, the Federal Centre for Health Education (BZgA) and the members of the European Expert Group on Sexuality Education introduce the concept of holistic sexuality education and offer a concrete overview that shows which topics sexuality education in European countries should entail, ordered according to age groups.

The publication is targeted at policy makers as well as educational and health authorities and other specialists working in these fields. In the countries themselves they are meant to serve as a guideline for the introduction of a holistic sexuality education. They provide practical support and guidance for the elaboration of suitable curricula whilst also furnishing the arguments and rationale for the introduction of such a holistic sexuality education in each country.

The Standards are based on a positive interpretation of sexuality which is regarded as a natural part of human development and a central aspect of human being throughout life. Such topics as HIV/AIDS, unwanted

pregnancies and sexual violence are embedded in an all-embracing education that focuses on the self-determination of the individual and people's responsibility for themselves and others. Holistic sexuality education gives children and young people unbiased, scientifically correct information on all aspects of sexuality and, at the same time, helps them to develop the skills to act upon this information. It hence prevents sexual ill health and:

- supports children in getting aware of their own limits and in being able to communicate these,
- supports children and young people to make self-determined and respectful choices and to communicate these, and
- supports children and young people in developing respectful and tolerant attitudes, which are a prerequisite for an equitable and just society.



The Standards are available for download in thirteen languages:  
<http://www.bzga-whocc.de/en/publications/standards-in-sexuality-education/>

This report is based upon a jointly conducted assessment of the International Planned Parenthood Federation European Network (IPPF EN) and the German Federal Centre for Health Education (BZgA), a WHO Collaborating Centre (WHO CC) for Sexual and Reproductive Health. The data of the assessment were collected between October 2016 and July 2017 by means of written expert interviews with representatives of governmental, NGOs and United Nations organisations in 25 countries and by collection of available data from international information sources.

The BZgA and IPPF EN would like to express their sincere thanks to the respondents of the questionnaire from governmental as well as from NGOs and UN organisations in all countries studied. The detailed answers and clarifications provided ensured that the report displays in-depth information on the status of sexuality education from different perspectives.

Special thanks go to the two research consultants and authors of this comprehensive report who conducted the assessment with highest dedication and thoroughness: Dr Evert Ketting and Olena Ivanova.

The team responsible for the concept and realisation of the research project comprised the following individuals from the BZgA and IPPF EN (in alphabetical order):

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