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Review article

Sexuality Education: Emerging Trends in Evidence and Practice

Nicole Haberland, M.P.H. [a,*], and Deborah Rogow, M.P.H. [b]

[a] *Population Council, New York, New York*
[b] *Independent Consultant, Santa Barbara, California*

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A B S T R A C T

The International Conference on Population and Development and related resolutions have repeatedly called on governments to provide adolescents and young people with comprehensive sexuality education (CSE). Drawing from these documents, reviews and meta-analyses of program evaluations, and situation analyses, this article summarizes the elements, effectiveness, quality, and country-level coverage of CSE. Throughout, it highlights the matter of a gender and rights perspective in CSE. It presents the policy and evidence-based rationales for emphasizing gender, power, and rights within programs—including citing an analysis finding that such an approach has a greater likelihood of reducing rates of sexually transmitted infections and unintended pregnancy—and notes a recent shift toward this approach. It discusses the logic of an "empowerment approach to CSE" that seeks to empower young people—especially girls and other marginalized young people—to see themselves and others as equal members in their relationships, able to protect their own health, and as individuals capable of engaging as active participants in society.

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IMPLICATIONS AND CONTRIBUTION

Comprehensive sexuality education (CSE) is gaining acceptance globally. CSE is most effective when it highlights a gender and rights perspective. An empowerment approach to CSE promises to empower young people to protect their own health.

In response to young people's needs for information and skills to protect their sexual and reproductive health (SRH) and lives, the global community has taken a series of measures to establish a policy framework for such education. The 1994 International Conference on Population and Development's (ICPD) Programme of Action, often referred to as the Cairo agenda, explicitly calls on governments to provide sexuality education to promote the well-being of adolescents and specifies key features of such education [1]. It clarifies that such education should take place both in schools and at the community level, be age appropriate, begin as early as possible, and foster mature decision making. ICPD+5 reinforces and further specifies the commitment of governments to provide formal and nonformal SRH information as part of promoting the well-being of adolescents.

These agreements also specifically aim to ameliorate gender inequality. For example, the ICPD Programme of Action articulates that programs address not only SRH and sexuality but also gender relations and equality, and violence against adolescents. ICPD+5 reinforces the call for comprehensive sexuality education (CSE) as part of "promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behavior, to protect them from early and unwanted pregnancy, sexually transmitted diseases including human immunodeficiency syndrome (HIV)/AIDS, and sexual abuse, incest and violence" (para 35 [b]) [2]. In 2009 and 2012, the Commission on Population and Development reaffirmed this, approving resolutions that called upon governments to provide young people with comprehensive education not only on human

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* Address correspondence to: Nicole Haberland, M.P.H., Population Council, One Dag Hammarskjold Plaza, New York, NY 10017.
E-mail address: nhaberland@popcouncil.org (N. Haberland).

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sexuality and SRH but also on gender equality and human rights, to enable them to deal positively and responsibly with their sexuality [3,4]. [1]Similarly, other international agreements such as the Ottawa Charter for Health Promotion articulate the effects of underlying or enabling conditions on health [6]. These documents reflect the interrelatedness of sexual health problems (such as sexually transmitted infections [STIs]/HIV), gender inequality, and human rights violations (such as intimate-partner violence) and clarify that the goals of sexuality education must inherently integrate these domains.[2]

The two decades since ICPD have seen efforts to clarify the definition of CSE and to implement, evaluate, and improve the quality of programs. This article reviews progress in each of these areas. Because the approach to gender has been particularly salient in each of these areas, this issue is highlighted throughout this article.

Defining Sexuality Education

In recent years, international agencies, such as the United Nations Population Fund (UNFPA) and the United Nations Educational, Scientific and Cultural Organization (UNESCO), and numerous researchers and practitioners have, as part of promoting CSE, reiterated the call for emphasizing social context—especially gender and rights—within programs. For example, to clarify all the elements that constitute CSE, UNFPA (2014) specifies the following in its operational guidance for CSE [10]:

(1) a basis in values and human rights of all individuals as a core component, not an add-on;
(2) thorough and scientifically accurate information about human rights, gender norms, and power in relationships, (including consent and decision making, sexual coercion, intimate-partner and gender-based violence, and sexual diversity); the body, puberty, and reproduction; relationships, communication, and decision-making; and sexual health (including STIs/HIV and AIDS, unintended pregnancy, condoms and contraception, and how to access health and other support services);
(3) a gender focus (gender norms and gender equality) as a stand-alone topic and also infused across other CSE topics; moreover, such gender content dovetails with efforts to keep girls in school and to promote an egalitarian learning environment;
(4) a safe and healthy learning environment;
(5) effective teaching approaches that are participatory, help learners personalize information, and strengthen their skills in communication and decision making and in critical thinking;
(6) youth advocacy and civic engagement in program design but also in empowering learners beyond the curriculum, as agents in their own lives and leaders in their communities;
(7) cultural appropriateness, tailored as needed for distinct subpopulations.

Other international agencies such as UNESCO and the International Planned Parenthood Federation (IPPF) also advocate for a CSE approach that recognizes and promotes human rights; gender equality; and the knowledge, values, and skills necessary for HIV prevention and sexual health [11–13]. The International Technical Guidance on Sexuality Education (ITGSE): Volume 1 [14], which carries the logos of UNAIDS (Joint United Nations Programme on HIV and AIDS), UNESCO, UNICEF, UNFPA, and World Health Organization (WHO), within one of the characteristics of effective programs, notes gender in its description of a key curriculum characteristic: “In order to be effective at reducing sexual risk behavior, curricula need to examine critically and address these gender inequalities and stereotypes” (Vol.1, p.20, ITGSE).

This emphasis is not simply a topic add-on. Rather, it rests on the view that sexuality education seeks explicitly to empower young people—especially girls and other marginalized young people—to see themselves and others as equal members in their relationships, able to protect their own health, and as individuals capable of engaging as active participants in society. Although the mandate to emphasize underlying or enabling conditions affecting health is articulated in such documents as the Ottawa Charter for Health Promotion, ICPD, and other international agreements, the sexuality education field has only gradually, and sometimes unevenly, begun to integrate this approach. Indeed, relatively few CSE programs address empowerment or gender equality in meaningful, consistent ways [15,16].

How to succinctly characterize such programs in ways that reflect and reinforce the evolving shift has been a challenge. Unfortunately, terminology has remained imprecise. Although CSE is clearly contrasted with “abstinence-only” education (abstinence-only refers to programs that exclusively promote abstinence and do not provide information about condoms and contraception, whereas CSE provides accurate information about condoms and contraception, sexuality, and reproduction), the other elements encompassed by the CSE label varies. Many international documents—including documents by the authors of this article—have resorted to somewhat awkward add-ons to the CSE label, such as “gender sensitive,” “gender-and-power-focused,” “gender-transformative,” “critical-thinking-oriented,” “rights-based,” “citizenship-oriented,” and “empowerment-oriented” to specify that these elements are included. Because it is useful to distinguish between CSE programs that do and do not address gender/power, for this article, we use the term “conventional CSE” to refer to programs that address condoms/contraception but fail to emphasize gender/power. Borrowing from Gutierrez et al. [17] and from numerous on-the-ground programs, we refer to an “empowerment approach to CSE” to refer more explicitly to sexuality and HIV education programs that do emphasize gender/power, to explicitly name the most neglected or poorly understood elements identified in the ICPD, and to more fully

[1] See also the United Nations Fourth World Conference on Women Platform for Action, which states that “Actions to be taken by Governments, international bodies including relevant United Nations organizations, bilateral and multilateral donors, and nongovernmental organizations […] (k) Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality” [5].

[2] These policy commitments have also been highlighted in various regional and high-level documents, including the 2005 Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa (also known as the Maputo Protocol [7]), and the Latin American Ministerial Declaration [8] articulating a commitment by all countries in that region to provide sexuality education. In 2010, the United Nations Special Rapporteur on Education [9] further emphasized that sexuality education should “focus on gender norms, roles and relationships.”

reflect the letter and spirit of the Ottawa Charter for Health Promotion.[3]

The difference in nomenclature often reflects a different theoretical orientation. Conventional CSE curricula are generally based on a theory of behavior change (such as social learning or social cognitive theory), which holds that people learn by observing others. Curricula based on these theories emphasize learning situations (such as role-plays or learning what one's peers practice) considered more likely to lead to behavior change. They may also draw on social norms theory, the idea that behavior can be changed by helping learners understand that their perceptions of their peers' sexual activity and attitudes may be inaccurate.

CSE that emphasizes empowerment may incorporate these theoretical approaches—and recognizes that knowledge confers some power—but also extends them. For example, implicitly or explicitly, such curricula encompass feminist theory, which predicts that coming to understand how gender inequality is socially constructed allows personal and critical reflection about gender norms, leading to different decisions and behaviors [18]. Hence, feminist theory, such as the Theory of Gender and Power [19], helps learners understand the origins of peers' misperceptions (e.g., social expectations for boys to "score") and to critique these norms. An empowerment approach to CSE also tends to draw on the Freirian theory that posits that education can (and should) empower learners to recognize how social inequities give rise to problems people experience as individuals [20]. These theories lead to an emphasis on teaching approaches that engage learners to question prevailing norms through critical thinking and analysis about their social context. The aim is that as learners adopt more egalitarian attitudes and relationships, they will adopt different behaviors and feel empowered to apply their principles and values in actions and—among other positive results—have better sexual health outcomes. The effectiveness of strengthening the empowerment focus of CSE is discussed in the following section.

What Is the Evidence of the Effectiveness of Sexuality Education?

What has been learned about effectiveness of comprehensive sexuality education in general?

A number of reviews have recently been completed on sexual risk reduction interventions. Some reviews and meta-analyses find that there is a dearth of effective programs [21–24], whereas others conclude that comprehensive sexual risk reduction programs are generally effective [25–28]. Indeed, some reviews find that about two-thirds of evaluations show reductions in targeted sexual risk behaviors [25,26,29].

Although such findings appear encouraging at first glance, a deeper look suggests room for improvement. First, the magnitude of the effect is typically quite modest. Second, it is notable that one-third of programs fail to demonstrate such a change in even one behavior. Third, because evaluations that assess biological outcomes are more expensive and complex, most interventions understandably define success in behavioral terms. However, many reviews recommend the use of biological outcomes as an objective measure of program efficacy rather than relying on self-reports of behavior change [22,24–27,30,31]. The concern is that, although behavioral data are important to collect (and shine light on the behavioral pathways through which an intervention has its effects), they are limited markers to evaluate success and to inform conclusions about program elements essential for such success. Unfortunately, among programs tracking health outcomes (i.e., reductions in STI or pregnancy rates), the success rate at which sexuality education programs affect these outcomes has been far lower [25,26,29]. That said, recent studies do point to very promising potential for certain approaches to sexuality education to reduce rates of STIs and unintended pregnancy.

Emphasizing gender and power: key to reducing sexually transmitted infections and unintended pregnancy

In part because few programs have historically emphasized gender and rights, its potential influence on effectiveness has received little attention. Yet there is mounting evidence that an empowerment approach to CSE is particularly effective. Prior reviews of different types of SRH programs—from reproductive health interventions for married girls, to men in maternity projects, to microcredit programs for marginalized women—have found that attention to gender issues improves reproductive health outcomes [32,33]). A recent analysis had a closer look at studies of sexual risk reduction programs that used the higher bar for measuring effectiveness, that is, those that measured STI or unintended pregnancy rates.[4] Not surprisingly, given the strong effect that gender and power have on SRH outcomes, programs that address issues of gender and power were markedly more likely to demonstrate significant positive effects on health outcomes than those programs that ignored gender and power [36].

Programs that ignored gender and power were conventional CSE programs, including some widely used and adapted curricula, some of which reported a change in a behavioral outcome but most of which failed to demonstrate a significant impact on pregnancy or STIs. In contrast, programs that addressed gender and power included, for example, programs such as the Horizons project, which is based on the Theory of Gender and Power and on Social Cognitive Theory. Conducted among African-American adolescent girls in the United States, this intervention emphasized ethnic and gender pride, HIV knowledge, communication, condom use skills, and healthy relationships. This intervention resulted in a substantial 35% lower risk of acquiring chlamydia among program participants; not surprisingly, condom use increased [37]. Another is a targeted program in Kenya to increase girls' understanding of the risks of intergenerational sex. This program used interactive and critical thinking methods to highlight the significantly higher HIV rates among older men and the implications of sugar daddy relationships. This intervention is particularly notable for two reasons:

[3] We welcome suggestions for other terms that both formally and functionally capture the importance of including critical thinking about gender and power, as well as better-known aspects of sexuality education.

[4] The hypothesis that gender content matters for CSE outcomes was based on abundant research demonstrating that gender norms, and gender-based power differentials within intimate relationships, profoundly influence sexual health outcomes. For example, young people who, compared with their peers, adopt egalitarian attitudes about gender roles (or who form relatively more equal intimate heterosexual relationships) are more likely to delay sexual debut, use condoms, and practice contraception; they also tend to have lower rates of STIs, HIV, and unintended pregnancy and are less likely to be in relationships characterized by violence [34]. Indeed, some researchers [35] characterize gender as the "gateway factor" to SRH outcomes.

(1) the program reduced pregnancy by 28% and (2) the program was school based [38]. Similarly, the gender- and empowerment-oriented curriculum Stepping Stones in South Africa resulted in a 33% reduction in the incidence of herpes simplex virus 2 [39].

Can an empowerment approach to comprehensive sexuality education have other beneficial effects?

A shift toward engaging young people in thinking critically about gender, power, and rights raises another question: might, or should, CSE aim at a wider range of outcomes—related to early marriage, sexual coercion, intimate-partner violence, homophobic bullying, girls' agency, school safety, sex trafficking, and/or gender norms? Indeed, the UNFPA Framework for Action on Adolescents and Youth from 2007 [40] addresses this constellation of issues, all of which in turn can contribute toward achieving the Millennium Development Goals on poverty, education, gender equality, maternal mortality, and HIV prevention.

Preliminary evidence suggests that efforts to address underlying social issues may pay off for multiple interrelated outcomes. For example, Project H reports that a gender-focused approach led to declines in self-reported use of physical violence among males [41]. Dupas [38], in the study described earlier, found a reduction in intergenerational sex. Similarly, the Stepping Stones curriculum also resulted in reduced reports of intimate partner violence [39]. Although gender norms are a gateway factor for a host of outcomes, more research is needed to demonstrate whether empowerment-focused CSE programs may provide a key to opening the gate.

Situation Analysis of Sexuality Education

Implementation

National programs. With few exceptions, governments have a long way to go to fulfill the Cairo agenda, even setting aside the mandate to address gender and rights. As a recent review by UNESCO [42] highlighting examples of scaled-up programs notes:

> Comprehensive sexuality education is a long way from being institutionalized in most low- and middle-income countries where the HIV epidemic poses a disproportionate burden. Even in countries with the highest HIV rates, there are relatively few examples of scaled-up, sustainable programs within educational curricula. (p16)

Although there is not a universal mapping of country CSE programs (and many are in flux), several multicountry reviews of sexuality/HIV/life skills education have been conducted. A UNESCO review of national policies and strategies to implement CSE in 28 countries in the Asia–Pacific region [43] found that six included detailed discussions of sexuality education. A 14-country review carried out as part of a thematic assessment of the UNFPA Framework for Action for Adolescents and Youth [15] found that many countries have made minor but insufficient advances in developing high-quality large-scale programs. Four countries had fully functioning programs; seven had components of strong, primarily school-based, CSE programs; and three countries relied on peer-education activities or small-scale adult-led programs.

Of course, with scale-up come serious challenges for maintaining program quality. For example, in Nigeria, where the federal government has been scaling up its Family Life and HIV Education program at the junior secondary school level, the curriculum was modified to achieve national consensus; in addition, the duration of teacher training was reduced [44].

Many countries have approved some type of HIV prevention education, often within the context of a life skills curriculum. The 28-country Asia–Pacific review found that a minority reference sexuality education in their education strategies [43]. A UNFPA/UNESCO/United Nations Children's Fund review of 10 countries in East and Southern Africa [16] found that most Ministries of Education have embedded HIV prevention education in a life skills curriculum. Not surprisingly, implementation at the classroom level can lag behind policy.

A notable exception is PESCC (In English, Project for Sexuality Education and the Construction of Citizenship), implemented by the Colombian Ministry of Education, with support from UNFPA. PESCC is unusual not only in its content (it is explicitly rights based, gender focused, and critical-thinking oriented) and age range (kindergarten through high school) but also in its flexibility: teachers at each school draw from core objectives to develop an appropriate curriculum [45].

Reaching the most vulnerable adolescents. The picture is sobering with regard to reaching marginalized adolescents such as girls who are out of school, married, living in extreme poverty, or engaged in transactional sex for economic survival; boys in gangs; substance abusers; HIV-positive youth; and those with learning disabilities. Only a few country programs in the 14-country study felt they were adequately engaging these young people. Complete discussion is required about how best to balance priorities between reaching the greatest number of young people through school-based CSE (almost by definition leaving out the most vulnerable) versus targeting more vulnerable out-of-school youth.

Tailored delivery models. How best to reach younger children—before gender and sexual norms consolidate and before many girls end their schooling—remains a challenge. Many CSE experts recommend starting (age appropriate) sexuality education as early as the age of 5 years; the ITGSE [14] and the WHO/Europe and the Federal Centre for Health Education (BZgA) Standards for Sexuality Education in Europe [46] designate key concepts to present children at different ages. For example, ITGSE suggests that a key point to teach 5–8 year olds is that "Some diseases can be transmitted from one person to another"; for ages 9–12 years, the analogous point is "The vast majority of HIV infections are transmitted through unprotected penetrative sexual intercourse with an infected partner" (v.2, p.97) [14]. Although such staging of content has an obvious logic, it runs up against a number of challenges. First, in some settings, students may be years behind in school [47]. CSE programs designed and delivered in fifth grade will be sorely inappropriate for a 15 year old who is behind grade for age. Second, because the average number of years of schooling, age of sexual debut and of marriage, and other factors vary from one setting to another, age-fixed content may not adequately allow for cultural diversity. Where resources are available, however, training and support may be directed to address these issues.

Although some countries begin life skills education in primary school, there is an absence of literature on these efforts. There are promising reports from community-based programs (not school based) reaching girls aged as young as 8 years, all of

which place emphasis squarely on girls' empowerment [48–50]. One benefit of such programs is that they reach girls before gender norms are consolidated, before girls have to manage menstruation, before they find themselves being declared suitable for sex and marriage, before both boys and girls begin forming sexual relationships, and before school enrollment falls for poor youth (and especially girls) in general.

What we know about current program quality

Curriculum. Unfortunately, reliance on abstinence-only approaches, which have not proven effective, remains strong. In the 14-country study carried out by UNFPA, at least half the countries had abstinence-based programs [15]. The 2012 East and Southern Africa curriculum review [16] reported that, in general, although content was age appropriate and addressed the topic of communication skills reasonably well, the main gaps included information about male/female condoms and contraception and other SRH topics (e.g., reproduction, STIs, abortion, where to access services, male circumcision, puberty). Attention to gender tended to be weak or contradictory.

Although there is thus a considerable way to go, a notable shift has been observed. Compared with even 5 years ago, there are increasing numbers of examples around the world of curricula in place or under development that emphasize gender and rights, both in the public sector and among NGOs [51].

Teacher skill. Strengthening teacher skill is an urgent priority for scaling up or improving CSE. To enable young people to personalize what they learn and apply it in their lives, CSE uses diverse and interactive methods. These methods involve not only cognitive learning but personal reflection and critical thinking (e.g., about gender norms) and practice with new skills (e.g., for assertive communication).

Classroom culture also becomes part of an informal curriculum. The World Values Survey studies find that a classroom in which students can freely express themselves in a supportive environment builds democratic values and that support for democratic values aligns more closely with support for gender equality than with any other attitudinal variable [52]. A classroom in which young people develop their critical thinking skills also equips them to question their social context and the norms and behaviors that undermine their health, well-being, and rights. Hence, at the broadest level, fostering agency and gender equality not only contribute toward better sexual health but also lay the groundwork for meaningful citizenship.

Nevertheless, most education systems—while they include critical thinking skills among the established learning standards—tend to be poorly equipped to nurture these skills. Classes are large, and teaching often reverts to lecturing and rote learning—including for HIV prevention/sexuality education. For example, the 10-country African review assessed teaching approaches as outlined in the materials and found, overall, inadequate attention to affective (emotional) learning objectives; weak attention to engaging critical thinking skills or a democratic classroom culture. Moreover, many teachers are simply not comfortable with the topic of sexuality. Cynthia Lloyd [53] cites the "persistence of gender bias" among teachers as an additional constraint on the effectiveness of many CSE programs; she points to It's All One Curriculum[5] as a useful guide for strengthening education about gender equality both in and out of schools.

A number of efforts are underway to strengthen CSE pedagogy. Transforming teaching methods for CSE, however, requires more than one-shot preservice training and in-service workshops. Rather, it has bold implications for pedagogy more broadly and thus for education reform. At the global policy level, CSE—especially a model that engages young people in thinking critically about gender and rights—cannot advance in the public sector without a major investment in strengthening teacher skill. How to tackle this challenge is a considerable dilemma.

Linkages to protective factors in the wider environment. CSE programs do not function in a vacuum. Policies and programs are beginning to address a range of factors beyond the curriculum, including the culture of learning, that enhance—or undermine—adolescents' sexual health and well-being. One concern is the school environment, too often characterized by the harassment and coercion of girls (including by teachers) and by the bullying of boys who do not conform to conventional gender stereotypes [55–57]. Another is that young people often have no way to access welcoming sexual health services. A recent WHO publication recommended that CSE link with programs that provide preventive services such as medical male circumcision and the HPV vaccine [58].

The social environment exerts a powerful effect on young people's sexual health and rights—both in reinforcing norms and by shaping opportunities and challenges. UNESCO has noted the synergy between CSE, schooling in general, and gender equality measures [59]. In some settings, CSE programs are seeking ways to connect to efforts with overlapping goals in other sectors—for example, girls' financial literacy programs, media campaigns promoting the prevention of gender-based violence, and advocacy for establishing appropriate legal frameworks—that can influence the reach and effect of investments in CSE.

Setting a Research Agenda

Our analysis has pointed to a number of gaps in the evidence. We believe it would be useful to:

(1) Invest in studies that assess sexuality education programs—either alone or as part of multicomponent interventions—using biological and/or health outcomes, such as pregnancy, STIs, and/or HIV.
(2) Support rigorous evaluation of interventions aimed at affecting multiple outcomes, including health, social, and education outcomes.
(3) Broaden indicators to also include such contextual factors as power in sexual relationships, context of sex, the school environment, harassment, and other variables that reflect the multiple factors that influence sexual risk and indicate what the implications are for interventions.
(4) Conduct rigorous evaluations designed to identify "key characteristics" of effective programs and that recognize the multiple contextual factors that influence adolescent sexual behavior.
(5) Support multiarm longitudinal studies that examine the outcomes of primary-level CSE that emphasizes gender and

[5] *It's All One* [54] is a peer-reviewed resource for developing CSE that is both rights based and gender focused. It was produced by an international working group composed of three developing country organizations (Girls Power Initiative; CREA; and Mexfam) and four international organizations (International Women's Health Coalition; IPPF; IPPF/Western Hemisphere Region; and the Population Council).

human rights. Such research can help answer whether reaching a wider swath of children at a young age can have beneficial effects on those who are likely to end their schooling at age 12–14 years.

(6) Document implementation of interventions, for program improvement, interpretation of study findings, and to provide adequate detail in study write-ups.

To realize their SRH and rights, young people need and are entitled to CSE. However, more efforts and action are needed to convince governments and other stakeholders to invest resources and effort in this area. First, there is a need to strengthen and to disseminate the evidence that curricular emphasis on gender, power, and rights improves health outcomes. Second, during ongoing negotiations about ICPD Beyond 2014 and after Millennium Development Goals and the Social Development Goals, there is a need to reinforce that the Cairo vision calls on governments not only to provide young people with information and skills as part of CSE but also to promote gender equality and human rights (what we refer to in this article as an empowerment approach to CSE). We must advocate for CSE not only as a health measure but also, by weaving content on gender and power throughout, as a way to help countries achieve post-2015 international development goals on gender equality and as a potential strategy to strengthen education overall. Investment should be made in interventions aimed at multiple (health, social, and academic) outcomes.

Furthermore, there is a need to develop and implement strategies for integrated primary education about puberty, gender, and fairness/rights and to place greater emphasis on reaching vulnerable youth, including married girls. It will be important to translate and disseminate useful curriculum resources. Finally, robust teacher training approaches that allow teachers to internalize learning about gender issues and to practice and master new pedagogies should be applied.

References

[1] United Nations. International Conference on Population and Development, Cairo, 5–13 September, 1994. Programme of Action. New York: United Nations; 1995. A/CONF.171/13/Rev.1.

[2] United Nations. Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development. New York: United Nations; 1999 (A/RES/S-21/2).

[3] United Nations. Commission on Population and Development Resolution 2009/1 (para 7) E/CN.9/2009/5. Available at: http://www.un.org/en/development/desa/population/commission/pdf/42/CPD42_Res2009-1.pdf. Accessed February 22, 2014.

[4] United Nations. Commission on Population and Development Resolution 2012/1 Adolescents and youth. E/CN.9/2012/8. Available at http://www.un.org/en/development/desa/population/pdf/commission/2012/country/Agenda%20item%208/Decisions%20and%20resolution/Resolution%202012_1_Adolescents%20and%20Youth.pdf. Accessed February 22, 2014.

[5] United Nations. Fourth World Conference on Women, Platform for Action. Paragraph 108(k). Available at: http://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf. Accessed August 11, 2014.

[6] World Health Organization. 1986. The Ottawa charter for health promotion. Available at: http://www.who.int/healthpromotion/conferences/previous/ottawa/en/. Accessed February 17, 2014.

[7] African Union. Protocol to the African charter on human and peoples' rights on the rights of women in Africa. Available at: http://www.achpr.org/instruments/women-protocol/. Accessed August 11, 2014.

[8] Ministers of Health and Education. Preventing through education: First meeting of Ministers of Health and Education to stop HIV and STIs in Latin America and the Caribbean, August 1, 2008. Available at: unaids.org/en/Resources/PressCentre/Featurestories/2009/July/20090731edu/. Accessed October 29, 2011.

[9] United Nations. Report of the United Nations Special Rapporteur on the right to education, July 23, 2010. Sixty-fifth session of the General Assembly. Available at: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N10/462/13/PDF/N1046213.pdf?OpenElement. Accessed August 11, 2014.

[10] Operational guidance for comprehensive sexuality education. New York: United Nations Population Fund; 2014.

[11] United Nations Educational, Scientific and Cultural Organization and United Nations Population Fund. Youth Compr Sex Education Fact Sheet. Available at: http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-sexuality-education.pdf. Accessed August 11, 2014.

[12] International Planned Parenthood Federation. IPPF framework for comprehensive sexuality education. Available at: http://ippf.org/resources/publications/ippf-framework-comprehensive-sexuality-education. Accessed January 25, 2013.

[13] International Planned Parenthood Federation. Exploring new territories: Dialogues from a consultative meeting on comprehensive sexuality education. Available at: www.ippf.org/system/files/exploring_new_territories_2012.pdf. Accessed January 25, 2013.

[14] International technical guidance on sexuality education, Volumes 1 and 2. Paris: United Nations Educational, Scientific and Cultural Organization, 2009.

[15] Kaidbey, Mona. 2011. Sexuality education review, executive summary. Internal United Nations Population Fund review document, unpublished.

[16] Sexuality education: A ten-country review of school curricula in east and southern Africa. Paris: United Nations Educational, Scientific and Cultural Organization and New York: United Nations Population Fund; 2012.

[17] Gutierrez L, Oh HJ, Gillmore MR. Toward an understanding of (Em)Power(Ment) for HIV/AIDS prevention with adolescent women. Sex Roles 2000; 42:581–611.

[18] Tickner AJ. Patriarchy. In Jones RJB, ed. Routledge encyclopedia of international political economy: Entries P-Z. Oxford, UK and New York, NY: Routledge, Taylor & Francis Group; 2001:1197–9.

[19] Connell RW. Gender and power. Stanford, CA: Stanford University Press; 1987.

[20] Freire P. Pedagogy of the oppressed. 30th Anniversary Edition. New York, NY: Continuum Books; 2000.

[21] DiCenso A, Guyatt G, Willan A, Griffith L. Interventions to reduce unintended pregnancies among adolescents: Systematic review of randomized controlled trials. BMJ 2002;324:1426.

[22] Magnussen L, Ehiri J, Ejere H, Jolly P. Interventions to prevent HIV/AIDS among adolescents in less developed countries: Are they effective? Int J Adolesc Med Health 2004;16:303–23.

[23] Paul-Ebhohimhen VA, Poobalan A, van Teijlingen ER. A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa. BMC Public Health 2008;8:4.

[24] Michielsen K, Chersich MF, Luchters S, et al. Effectiveness of HIV prevention for youth in sub-Saharan Africa: Systematic review and meta-analysis of randomized and non-randomized trials. AIDS 2010;24:1193–202.

[25] Kirby DB, Laris BA, Rolleri LA. Sex and HIV Education Programs: Their impact on sexual behaviors of young people throughout the world. J Adolesc Health 2007;40:206–17.

[26] Underhill K, Operario D, Montgomery P. Systematic review of abstinence-plus HIV prevention programs in high income countries. PLoS Med 2007;4: e275.

[27] Mavedzenge SN, Doyle A, Ross D. HIV prevention in young people in sub-Saharan Africa: A systematic review. J Adolesc Health 2011;49:568–86.

[28] Johnson BT, Scott-Sheldon LA, Huedo-Medina TB, et al. Interventions to reduce sexual risk for human immunodeficiency virus in adolescents: A meta-analysis of trials 1985–2008. Arch Pediatr Adolesc Med 2011;165:77–84.

[29] Kirby D. The impact of sex education on the sexual behaviour of young people, Population Division Expert Paper No. 2011/12. New York, NY: United Nations Department of Economic and Social Affairs; 2011.

[30] Harrison A, Newell M-L, Imrie J, Hoddinott G. HIV prevention for South African youth: Which interventions work? A systematic review of current evidence. BMC Public Health 2010;10:102.

[31] Ross DA. Behavioural interventions to reduce HIV risk: What works? AIDS 2010;24:S4–14.

[32] Rottach E, Schuler SR, Hardee K. Gender perspectives improve reproductive health outcomes: New evidence. Washington, DC: USAID; 2009.

[33] Gay J, Hardee K, Croce-Galis M, et al. What works for women and girls: Evidence for HIV/AIDS interventions. New York: Open Society Institute 2010. Available at: http://populationaction.org/wp-content/uploads/2011/12/what-works.pdf. Accessed August 11, 2014.

[34] Rogow D, Haberland N. Sexuality and relationships education: Toward a social studies approach. Sex Education 2005;5:333–44.

[35] Middlestadt SE, Pulerwitz J, Acharya K. et al. Evidence for gender as a gateway factor to other behaviors—Ethiopia. The Health Commun Partnership's End of Project Meeting. Available at: www.jhuccp.org/legacy/pubs/HCP_endofproject/3Acharya.ppt. Accessed December 3, 2012.

[36] Haberland N. What happens when programs emphasize gender? A review of the evaluation research. Presented at UNFPA global technical consultation on comprehensive sexuality education, Bogota, Colombia. November 30, 2010.

[37] DiClemente RJ, Wingood GM, Rose ES, et al. Efficacy of sexually transmitted disease/human immunodeficiency virus sexual risk-reduction intervention for african-american adolescent females seeking sexual health services: A randomized controlled trial. Arch Pediatr Adolesc Med 2009;163:1112–21.
[38] Dupas P. Do teenagers respond to HIV risk information? Evidence from a field experiment in Kenya. Am Econ J Appl Econ 2011;3:1–34.
[39] Jewkes R, Nduna M, Levin J, et al. Impact of stepping stones on incidence of HIV and HSV-2 and sexual behavior in rural South Africa: Cluster randomised controlled trial. BMJ 2008;337:a506.
[40] Framework for action on adolescents and youth/opening doors with young people: 4 keys. New York, NY: United Nations Population Fund; 2007.
[41] Engaging men to prevent gender-based violence: A multi-country intervention and impact evaluation study. Report for the United Nations Trust Fund. Washington, DC: Instituto Promundo; 2012.
[42] Comprehensive sexuality education: The challenges and opportunities of scaling up. Conference-Ready Version. Paris: United Nations Educational, Scientific and Cultural Organization; 2012.
[43] UNESCO Bangkok. Review of policies and strategies to implement and scale up sexuality education in Asia and the Pacific. Available at: http://unesdoc.unesco.org/images/0021/002150/215091e.pdf. Accessed January 15, 2013.
[44] Can School-Based Sexuality Education Advance Education and Gender Equality? Learning from Nigeria's family life and HIV education program. New York, NY: International Women's Health Coalition, (forthcoming).
[45] Ministerio de Educaciòn Nacional, Republica de Colombia. Educaciòn para la sexualidad. Available at: http://www.colombiaaprende.edu.co/html/productos/1685/article-171669.html. Accessed August 11, 2014.
[46] Standards for sexuality education in Europe: A framework for policy makers, educational and health authorities and specialists. Cologne, Germany: World Health Organization/Europe and Federal Centre for Health Education (BZgA); 2010.
[47] Lloyd C, Young J. New lessons: The power of educating adolescent girls. New York, NY: Population Council; 2009.
[48] Catino J, Colom A, Ruiz MJ. Equipping Mayan girls to improve their lives. Transitions to adulthood. Brief No. 5. New York, NY: Population Council; 2011.
[49] Erulkar A, Ferede A, Girma W, Ambelu W. Evaluation of 'Biruh Tesfa' (Bright Future) program for vulnerable girls in Ethiopia. Vulnerable Child Youth Stud 2013;8:182–92.
[50] Svanemyr J, Amin A, Robles OJ, et al. Creating an enabling environment for adolescent sexual and reproductive health a framework and promising approaches. J Adolesc Health 2015;56:S7–14.
[51] Rogow D, Haberland N, Del Valle A, et al. Integrating gender and rights into sexuality education: Field reports on using It's All One. Reprod Health Matters 2013;21:154–66.
[52] Pettersson T. Basic Values and Civic Education: A comparative analysis of adolescent orientations towards gender equality and good citizenship. Available at: www.worldvaluessurvey.org/library/. Accessed August 11, 2014.
[53] Lloyd CB. The role of schools in promoting sexual and reproductive health among adolescents in developing countries. In: Malarcher S, ed. Social determinants of sexual and reproductive health Informing future research and programme implementation. Geneva: World Health Organization; 2010.
[54] It's All One Curriculum: Guidelines and activities for a unified approach to sexuality, gender, HIV, and human rights education. New York, NY: Population Council, International Sexuality and HIV Curriculum Working Group, 2009 and 2011.
[55] USAID. The Safe Schools Program. Available at: http://pdf.usaid.gov/pdf_docs/pdacp103.pdf. Accessed May 19, 2014.
[56] Amnesty International. What we do. Available at: http://www.amnesty.org/en/human-rights-education/what-we-do. Accessed May 19, 2014.
[57] Pan American Health Organization. Countries must eliminate homophobia and transphobia. Available at: http://www.asylumlaw.org/docs/sexualminorities/LatinAmHIV051509.pdf. Accessed May, 19 2014.
[58] WHO Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries. Geneva: World Health Organization; 2011.
[59] Haberland N. Ensuring education benefits girls to the full: Synergies between education, gender equality, HIV and sexual and reproductive health. In: Gender equality, HIV and education. Good policy and practice in HIV and health education. Booklet 7. Paris: United Nations Educational, Scientific and Cultural Organization; 2012:17–23.