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Chapter 4

SEXUALITY EDUCATION IN EUROPE AND CENTRAL ASIA: RECENT DEVELOPMENTS AND CURRENT STATUS

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ABSTRACT

The field of sexuality education (SE) has been rapidly evolving over the past decade. This chapter provides an overview of the current status of SE in the WHO European Region (Europe and Central Asia). It is

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based on a 2016–2017 assessment by the German Federal Centre for Health Education (BZgA) and the International Planned Parenthood Federation European Network (IPPF EN). About half of the countries (25/53) in the WHO European Region were included in the assessment, selected to be representative of the region. A questionnaire was sent to two respondents with different profiles in each country: civil servants in the responsible national ministries (mostly education or health), and staff of the national member associations of IPPF EN. All 25 IPPF EN member associations and 15 of the 25 ministries responded. Data collected through the questionnaire was supplemented by international data sources and local research reports. Since 2000, considerable progress has been made in developing and implementing SE in the European Region. In 18 of the 25 countries, there is currently a legal basis for SE. In three of the seven remaining countries, meaningful initiatives are taking place to develop SE in schools. SE programmes are almost always integrated into wider teaching subjects, such as biology, life skills or health education; stand-alone programmes are rare. In 10 of the 25 countries, the SE programme has a clearly comprehensive character, and in four more countries, the programme is tending to become more comprehensive. In 11 of the 21 countries with SE programmes, the programmes are mandatory; in seven countries, SE is partly mandatory; and it is optional in only four countries. Opposition to SE provision in schools is still strong in half of the countries. In countries with fully developed comprehensive SE programmes, young people mention the school as an important source of information about sexuality and teenage birth rates are (very) low. Conversely, teenage birth rates tend to be very high in countries in which SE is virtually absent. These correlations do not necessarily indicate causal relationships, since other factors may be influencing the outcomes or mediating the correlations.

Keywords: sexuality education, school, young people, sexual and reproductive health (SRH), Europe and Central Asia

INTRODUCTION

Sexuality education (SE) has a long history in Europe – starting in Sweden, where it became a mandatory subject for school education in 1955. Most other countries in Western Europe also started to introduce SE in schools during the 1960s and 1970s. Some Southern European countries followed during the last two decades of the past century. Estonia was the

first country from the former Soviet Union to introduce mandatory SE in schools, in 1996. A few other countries in this part of the region have followed Estonia's example, and the process is still ongoing.

In recent decades, the field of SE has been evolving rapidly, and little is known about the current status of SE in Europe and Central Asia. This chapter presents the results of an assessment of the status of SE in the WHO European Region[30] that was conducted at the end of 2016 and early 2017. It is based on a more extensive report published in 2017 by the German Federal Centre for Health Education (BZgA) and the International Planned Parenthood Federation European Network (IPPF EN).

This introductory section will expand on the concept of sexuality education, recent developments in the field and rationales for the assessment of SE.

THE TERM 'SEXUALITY EDUCATION'

International organizations have used different definitions of 'sexuality education', although there is ample international agreement on content and preferred approaches. A recent UNESCO report [1] devotes an Annex to the issue (see Annex 2 in reference 1). At the country level, various terms are also used for SE. In 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 now become rather unusual, and so far as it is still applied, it tends to include very few elements that are currently perceived as comprehensive and hence essential for sexuality education. Because school SE in the European Region is almost always fully integrated into other subjects in the curriculum ('stand-alone' programmes are rare), SE is often not even visible as a learning theme and does not have its own label. It may, therefore, appear that there is no SE,

[30] Hereafter referred to as the 'European Region', which also includes the five Central Asian countries.

although in the vast majority of European countries it is actually being taught in schools.

When the BZgA and the WHO Regional Office for Europe started developing their 'Standards for Sexuality Education in Europe' in 2008, they used the term 'holistic sexuality education' for recommended content and approaches. In 2016, it was decided to replace this term with 'comprehensive sexuality education', since by that time all relevant international organizations had started to use the latter term for almost the same content and approach.

However, the term 'sexuality education' (SE) is used in this chapter, for two reasons. Firstly, the term 'holistic' or 'comprehensive' sexuality education is hardly used at the country level, if at all. Secondly, the two terms refer to a type of SE that is characterized by a set of clearly defined quality criteria. In practice, most of these quality criteria are adequately met in fewer than half of the countries throughout the European Region, so that most programmes cannot be called 'holistic' or 'comprehensive'. For the same reason, the acronym 'CSE' is not used as the overarching term for *all* programmes in the region.

RECENT DEVELOPMENTS IN SE IN THE EUROPEAN REGION

During the past decade, BZgA and IPPF EN have both played an important role in stimulating and providing guidance on the introduction and further development of SE in the European Region, along with many other national and international organizations and initiatives.

In 2008, the BZgA, a German governmental organization, and a WHO Collaborating Centre initiated the work of the 'European Expert Group on Sexuality Education', which aims to improve the quality of SE and to foster the implementation of it throughout the European Region. The group consists of about 20 members from a dozen countries who work for governmental, non-governmental, academic and UN organizations in the field of SE. Under the guidance and coordination of the BZgA and the WHO Regional Office for Europe, the group has produced various policy and practice guidance and research documents on SE, starting with the

'Standards for Sexuality Education in Europe' [2], which is available in 11 languages and has become an important guiding document for the development of SE in various countries throughout the European Region. Related documents on the implementation of SE, its evaluation and the training of sexuality educators have followed [3-5].

The IPPF EN has member associations in the majority of countries in the European Region, and SE is a spearhead issue for the organization. Through its member associations, the IPPF EN supports the development, acceptance, and implementation of SE in many countries, particularly in Central and Eastern Europe and Central Asia. As a non-governmental organization, the IPPF EN also fulfills a crucial advocacy role for legal and policy changes in favor of SE. Like the 'European Expert Group on Sexuality Education', in which IPPF EN is represented, it also contributes to the exchange of information and experience in this field between European and Central Asian countries, and also globally.

Towards the end of the first decade of this century, other international organizations also started to become more active in this field. In 2009, UNESCO released an overview of studies on the impact of SE and a related volume on topics and learning objectives for SE [6][31]. In the same year, the Population Council, IPPF, and others also published international guidelines on SE [7]. In 2014, the United Nations Population Fund (UNFPA) released its 'Operational Guidance' with a global perspective [8]. This growing international commitment to SE stimulated rapid developments in this field, also in the European Region.

INFORMATION ABOUT THE STATUS OF SE IN THE EUROPEAN REGION

Two earlier comparable reports, published in 2006, assessed SE in Europe and were used as starting-points for the current assessment. The

[31] UNESCO will be publishing an updated version of this report in 2018.

first one resulted from the SAFE[32] project [9], implemented in 26 countries in Western, Northern and Central Europe, but not countries in Eastern Europe or Central Asia. The second, produced by the BZgA [10], presented data from 14 countries in Europe and two in Central Asia. Six of these countries were not included in the SAFE report.

The current assessment fills a gap in the information available about the status of SE in the European Region for the following reasons:

1. SE is a field in a state of rapid development, and many changes have taken place in this area since 2006.
2. Respondents: This assessment systematically contacted representatives of both governmental and non-governmental agencies in the selected countries, and the information provided by the two sides is often complementary.
3. The questionnaire used for this assessment was more elaborate than in the previous two surveys.
4. Unlike the two previous assessments, the current one is fairly representative for the entire European Region.

METHODS

This chapter is based on two data sources: 1) a questionnaire that was specially developed to assess the status of SE in the European region, and 2) data available in the literature. Data were collected in 25 of the 53 countries in the WHO European Region, three of that are in Central Asia. This sample is fairly representative of the WHO European Region.

Questionnaire

The questionnaire was based on the two earlier assessments of the status of SE in Europe, mentioned above, and covered five fields:

[32] SAFE: Sexual Awareness for Europe (2006–2012).

1. Laws and policies on SE;
2. Implementation of SE in practice;
3. Opposition and barriers to SE;
4. Youth-friendly SRH services; and
5. Research data on adolescent SRH.

The questionnaire was piloted in two countries – Bosnia-Herzegovina (Sarajevo) and the Netherlands – and adapted on the basis of the results of the pilot study. The questionnaire was translated into Russian for use in the Russian Federation, Kazakhstan, Kyrgyzstan, and Tajikistan.

In each country, two types of organizations were contacted: a governmental agency that is responsible for SE (for instance, the Ministry of Education or Health) and a non-governmental agency, which in all cases except Georgia was the IPPF EN member association in the selected country. In a few cases, the local UNFPA offices provided some additional answers to the questionnaire at the request of one of the country respondents.

All IPPF EN member associations completed the questionnaire. The questionnaire from the responsible government agency was not returned in 10 countries.[33] These non-responses occurred in countries in which the government was not involved in the subject, or only to a limited extent. Similar problems did not occur in identifying informed NGO respondents since the IPPF EN member associations in the countries in which SE is not yet well developed are all involved in advocacy for and/or provision of SE, and are therefore knowledgeable about the current status of the topic. In two cases (Germany and Switzerland), the questionnaire was filled in jointly by representatives of a governmental agency and the IPPF EN member association.

There were hardly any conflicting answers between the two respondents in the 15 countries in which both respondents replied. The two respondents gave divergent answers to a few factual questions in only one case, which was clarified at a later stage. Where the questions involved

[33] Non-response from the government agencies in: Bulgaria, Cyprus, Ireland, Kazakhstan, Kyrgyzstan, Macedonia FYR, Serbia, Spain, Tajikistan and Ukraine.

opinions or interpretations, there were a few more differences between the two respondents in each country. However, in the majority of cases, the answers given in the two questionnaires complemented each other, in the sense that the answers were given by government agencies mostly expressed the official government position, whereas the NGOs added information from an advocacy and implementation point of view. In all cases, requests for clarification were sent to the respondents after receipt of the questionnaires, and the questions were subsequently answered satisfactorily. After draft report paragraphs for each country had been prepared, these drafts were sent to the respondents for a final check. In some cases, when a national UNFPA office was strongly involved in the subject, it also reviewed the answers and responded through the initial respondents of the questionnaire.

Literature

As this is not a review paper, but rather a systematic assessment, the use of the literature was limited to three types of literature sources. The first type was national and international literature that provides information and guidance for the development and implementation of SE programmes. Secondly, literature providing international comparative data on the sexual behaviour of young people and essential demographic variables was used. Thirdly, the results of national surveys in countries in the European Region that included information about sources of information for young people about sexuality (including SE) were used. The latter sources were collected on request by the respondents to the assessment, through the survey questionnaire.

RESULTS

The topics addressed in this section are, in sequence: laws and policies related to SE; practical implementation and delivery of SE; SE for out-of-

school and vulnerable young people; opposition to SE; sexual and reproductive health (SRH) services for young people; and the SRH status of young people in the different countries. After this, a short overview is given of some internationally comparative indicators for adolescent sexual health and sexual behaviour in the region.

Unless otherwise indicated, all the information in this section is derived from responses to the questionnaire.

Laws, Policies, and Strategies Related to SE, and Influencing Factors

In this section, we will discuss laws, policies and strategies related to SE and its characteristics, as well as factors related to or influencing the legal/policy/strategic framework for SE, such as the status of SE in the overall curriculum, the use of the BZgA Standard for Sexuality Education, the existence of opposition, and the comprehensiveness of SE.

Table 1 presents an overview of the legal status of SE in the 25 countries in the European Region, as well as the factors that may influence this status.

Most often, 'legal status' means that one or more laws regulating school education include one or more paragraphs that specify which elements of SE should be taught in which schools and at which levels. It is rare that there is a separate law specifically dealing with SE alone. Laws can be very general, only roughly indicating what should be taught to whom, or very detailed, specifying precisely which subjects should be included in curricula for different levels. In a few countries, there are no legal documents regulating SE, but rather policies or strategies that could in the future become law.

In the majority of the countries surveyed (21 out of 25), there is a clear legal framework for SE in schools or at least some political support for it. Two of the latter countries (Cyprus and Latvia) have adopted a policy in which the need for SE is at least recognized, and in one country (Bosnia

and Herzegovina) there is only a strategy that calls for the introduction of SE in schools.

Table 1. Legal status of SE and potentially influencing factors in 25 European Region countries

Country	Year of last legal change[1]	Legal status	Status in curriculum	Use of 'Standards'[2]	Opposition to SE in society	Comprehen-siveness[3]
Albania	2012	Law	Mandatory	A + C	Yes	+++
Austria	2015	Law	Mandatory	A + C	Some	+++
Belgium (Flanders)	2010	Law	Mandatory	A + C	No	+++
Bosnia & Herzegovina*	2016	Strategy	Optional	A + C	Yes	+++
Bulgaria	2016	Law	Optional	A + C	Yes	N.A.[4]
Cyprus	2011	Policy	Partly man.	C	Yes	++
Czech Republic	2013	Law	Mandatory	C	Some	++
England	2017	Law	Partly man.	A	Some	+
Estonia	2011	Law	Mandatory	A + C	No	+++
Finland	2016	Law	Mandatory	C	No	+++
Germany	2002	Law	Mandatory	C	Some	+++
Georgia	None	No	N.A.	N.A.	Yes	N.A.
Ireland	2010	Law	Partly man.	Unknown	Some	+
Kazakhstan	2009	Law	Optional	Unknown	Yes	+
Kyrgyzstan	2015	Law	Optional	Unknown	Yes	++
Latvia	2013	Policy	Mandatory	Unknown	Yes	+
Macedonia FYR	None	No	N.A.	A	Some	N.A.
Netherlands	2012	Law	Mandatory	A + C	No	+++
Russian Federation	None	No	Partly man.	Unknown	Yes	+
Serbia	None	No	N.A.	N.A.	Yes	N.A.
Spain	2010	Law	Partly man.	N.A.	Yes	+
Sweden	2011	Law	Mandatory	N.A.	No	+++
Switzerland	2008–14[5]	Law	Partly man.	A + C	Some	+++
Tajikistan	2015	Law	Partly man.	Unknown	Yes	+
Ukraine	2013	Law	Mandatory	A	Some	+

* Canton of Sarajevo only.

[1] Change, adaptation or extension of law/decree/act, governmental policy or strategy.

[2] 'Standards' = WHO/BZgA (2010) Standards for Sexuality Education in Europe (SE guideline, available in 11 European languages). A. advocacy; C, curriculum development; N.A., not applicable.

[3] Summary index of SE comprehensiveness related to law, practice and in-country variation, based on six indicators in survey questionnaire: + = little; ++ = quite; +++ = highly comprehensive.

[4] New law is not yet implemented.

[5] Varies by language area (German, French and Italian).

However, in the latter country, there is a fully developed and comprehensive SE programme in one 'canton', i.e., Sarajevo. In many cases, the legal basis for SE has been periodically updated, and as a result, the latest adaptation has taken place in the past decade in almost all of the countries. The conclusion should be that school SE has now become the general norm in the European Region.

There is no national law, policy, or strategy related to SE in only four countries (Georgia, Macedonia FYR, the Russian Federation and Serbia). However, at least some form of school SE has been implemented or is being prepared in three of these countries. In Georgia, the UNFPA and a specialized national NGO (Tanadgoma) are in the process of developing a national SE curriculum in close contact with the Ministry of Education. In Serbia, there has been a successful SE pilot project in one province (Vojvodina), but it is uncertain whether this will be sustained and also whether it will be implemented in other provinces. In the Russian Federation, there is also some form of SE, which focuses almost exclusively on HIV/STI prevention. In Bulgaria, a law regulating SE was passed in 2016, but practical decisions on how to implement it had not yet been taken halfway through 2017. The most recent legal change took place in England, where a bill was passed in March 2017 that makes SE a mandatory teaching subject in *all schools* by 2019. Until now, it has only been mandatory in state schools.

Status in Curriculum: Mandatory or Optional Teaching Subject

An important aspect of the legal regulations is whether or not SE teaching is mandatory (obligatory). At present, there is wide variation among countries. For example, it may be that SE is only mandatory in some schools, but not in others. This is indicated in Table 1 by the term 'partly mandatory'. Another possibility is that teachers or learners may be able to choose the subject as one of more options, and this is usually referred to as 'optional'.

SE is a mandatory subject in all schools in only 11 of the 25 countries. In the remaining countries, it is either optional or is only mandatory in some regions or in particular schools (i.e., 'partly mandatory'). In almost

all cases, mandatory' means that SE is included in other teaching subjects that are mandatory, such as biology or health education. The subject is 'optional' when learners can also choose another subject instead of SE. This is only the case in four countries.

Use of 'Standards for Sexuality Education in Europe'

International guidelines on the teaching of SE, such as the WHO/BZgA 'Standards for Sexuality Education in Europe' [2] are widely used – in Europe as well – to promote the introduction of SE programmes in schools, since these guidance documents include a variety of reasons why the subject is important for learners and what the benefits of it are. The use of these documents in advocacy efforts can thus have an important impact on political decision-making and on improving the status of SE in a country.

The 'Standards' have been made available in 11 different European languages and have been used as an advocacy tool or for the development of SE curricula in more than half of the countries within the European Region. It has also been used for curriculum development in Georgia, but this process is still ongoing and this is therefore not included in the overview table. The 'Standards' have scarcely been used, if at all, in countries such as Ireland, Latvia, and Spain, although English, Latvian and Spanish translations are available.

In eight of the countries surveyed, the 'Standards' have been used for both advocacy purposes and for curriculum development. The document includes an extensive section outlining which subjects should ideally be taught at different educational levels – for the purposes of curriculum development. In four more countries, the document has only been used for the latter purpose, and in three other countries, it has only been used for advocacy purposes. Respondents in six countries felt unable to state to what extent the 'Standards' have been used for the two purposes.

Opposition to SE

In most countries, there is some degree of opposition to teaching SE in schools. This may be initiated by certain political parties, by organized

groups of parents, or by some religious leaders. Such opposition may be quite marginal, but it can also be very influential. In the latter case, it may very well create obstacles to the political decision to accept a legal bill that would make SE a mandatory teaching subject. For this reason, 'opposition to SE' is also discussed in this section.

It is important to note that in half of the countries (12 in total), SE is still a sensitive and sometimes heavily disputed issue. These tend to be the countries in which SE is only developing slowly, or not at all. In countries in which there is strong opposition to SE, there is often no law regulating SE; the programme tends not to be mandatory, and the 'Standards' tend to be used primarily or exclusively for advocacy purposes. These countries are mainly in Eastern Europe and Central Asia. However, in countries where there is serious opposition, an SE programme can nevertheless be developed and implemented. Albania is a good example of this: the Ministry of Education there is collaborating closely with national NGOs and international agencies in developing and implementing a national SE programme, since the adoption by the Ministry of Health, in 2012, of a sub-legal Act entitled 'Approval of the positioning paper on comprehensive sexuality education for young people in Albania'. The number of schools in which the new programme is running was still being extended at the end of 2016. On the other hand, there are five countries in which the respondents report that opposition to SE is hardly an issue, if at all: Belgium, the Netherlands, Estonia, Finland, and Sweden.

The counter-argument most frequently mentioned is that SE would lead to an early onset of sexual behaviour. It is remarkable that this idea is still widespread in the region since a large number of studies have rejected the claim [6, 11]. Another argument that is often used against SE is that SE is a task for parents, rather than for schools. However, where this argument is strong, the role of parents in educating their children on sexuality issues tends to be much weaker than in countries where there is little or no opposition to SE (data not shown). In Kyrgyzstan, for example, where there is substantial opposition to SE, only 10% of young people mentioned their parents as a source of information about sexuality, whereas 30% of

them mentioned the Internet and social media as sources for it and 56% mentioned 'friends and peers' as a source [12]. On the basis of this and other studies provided by the respondents, it appears that in countries in which parents exclusively claim this responsibility they do not often put it in practice – thus making their children more dependent on information from peers and often from misleading Internet sites.

Comprehensiveness of Sexuality Education

The legal status of SE may largely determine the degree of comprehensiveness of the teaching. The exact meaning of the term 'comprehensive' is discussed further below, but essentially it means that the SE teaching is adapted to the age and level of development of learners and that a broad range of sexuality-related issues are addressed. Legal documents may specify the degree of comprehensiveness, but do not always do so. It is also possible that this is largely left to the authority of schools and teachers.

International agencies working in the field of SE have given slightly different definitions of *'comprehensive'* sexuality education (CSE) [1, 2, 8, 9]. In order to assess whether countries follow a comprehensive approach, the WHO & BZgA [2] definition was used in this assessment, as follows:

> 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.'

In addition to this, several quality criteria have been formulated for CSE. The answers to six questions in the questionnaire were used to measure the degree of comprehensiveness of existing programmes in the region. These six indicators were:

1. Laws are supportive of comprehensive sexuality education;
2. Characterization of SE objectives and curriculum in terms of comprehensiveness;
3. Topics included in SE and how briefly or extensively they are dealt with;
4. Educational materials reflect comprehensive approaches;
5. The SE programme is mandatory;
6. Wide variation in the country in how SE is implemented in practice.

The results of the index of these six indicators are presented in the last column of Table 1.

The most comprehensive programmes (positive on 5 or 6 of the questions), indicated as '+++', are found in the Nordic countries and Western Europe, as well as recently also in Albania. A comprehensive programme has also been developed in Bosnia & Herzegovina, but until now it has only been implemented in the canton (region) of Sarajevo, and it is an optional programme that is not chosen by the majority of learners. Programmes and implementation were moderately comprehensive (i.e., positive on 3 or 4 of the questions) in three more countries: Cyprus, the Czech Republic and Kyrgyzstan (i.e., those indicated as '++'). In the remaining countries, the programmes cannot be called comprehensive.

An important indicator for comprehensiveness is the breadth of topics dealt with in SE (i.e., indicator 3 above). There is substantial variation in SE programmes in the region on this point. The questionnaire included a list of 15 such topics (plus two open topics that could be added), and respondents were asked to indicate how extensively these topics were included in their programmes. The results show that the topics that were most often and most extensively dealt with were: biological aspects of the reproductive system, HIV, STIs, pregnancy and birth, and contraception. Fewer programmes also included the issues of love, marriage, and/or partnership; gender roles; mutual consent to sexual contacts; and use of online media for information about sexuality. Issues that were least addressed included access to abortion services; sexual abuse and domestic

violence; sexual orientation; and, least dealt with, sexual pleasure. Programmes that are poorly comprehensive usually only cover biological issues and prevention of HIV/AIDS, STIs, and unwanted pregnancy, whereas the most comprehensive ones tend to include (almost) all the topics listed. For example, in the Russian Federation, the focus is almost exclusively on HIV/AIDS and STI prevention, whereas in neighboring Estonia almost all of the topics mentioned are discussed quite extensively in the course of a programme that is spread out over 7 years of school education.

Another crucial quality indicator for comprehensive SE, according to the 'Standards', is that a programme is age-appropriate and developmentally appropriate since the needs, interests, and level of understanding of younger children differ widely from those of their older peers, i.e., adolescents. By implication, this means that a programme should ideally be spread out over several years of learning and should not be concentrated into a few weeks or months at one particular age. The basics of the same topics should ideally be addressed at a relatively young age, and they should then be dealt with again in a more detailed way when learners are older and their interests and level of understanding have increased. The *comprehensive* SE programmes in the region usually meet this criterion: they start in primary school and continue in secondary school.

In the Netherlands, for example, there is one programme for primary schools and one for secondary schools. The programme for primary schools, called 'Itches in Your Tummy', is taught to learners in grades 7 and 8 of primary school when they are around 10–12 years old. The most popular programme for secondary schools is 'Long Live Love', which is used with 13–14-year-olds and is more explicit on issues such as love and attraction, (sexual) relationships and prevention of unwanted pregnancy and STIs. In Albania, the 'Life Skills and Sexual Education' programme starts when learners are around 10 years old and continues up to the age of 16 or older. During these years of implementation, the topics dealt with gradually become more detailed.

Responsibilities for Sexuality Education

Educational systems and responsibilities differ widely in the European Region, and responsibilities for developing and implementing SE curricula consequently vary widely as well [2, 3].

The development and implementation of a school-based SE programme usually involve the following steps:

1. Defining goals, objectives, and general guidelines;
2. Developing curricula that indicate the subjects that will be taught, and at which levels;
3. Developing lesson plans to be implemented by teachers (and training of teachers); and
4. Developing educational materials.

Government Level

On the basis of the responses to the questionnaire, it seems that who is responsible for what at the political level is largely determined by how closely a national Ministry of Education is involved in the process. At the political level, the national government often shares responsibility with lower-level authorities and administrations. For example, in federally organized Germany, the BZgA, a federal institution, coordinated the development of a national framework for SE that was developed by the federal states (step 1). In the second step, the development of curricula, the federal states had the main responsibility in Germany. At that level, various other organizations and groups were also involved, including NGOs and professional groups for education and health. The third and fourth steps, development of lesson plans, educational materials, and concrete implementation guidelines, take place at the community level.

The pattern is not only determined by the size of the country, but also by the degree of decentralized decision-making in general. In a much decentralized country like Switzerland, the role of the national government is limited, and the cantons fulfill most responsibilities. This is also the case in Belgium and the Netherlands. In both countries, the national government only decides on goals and objectives; curricula, lesson plans and the

development of materials and guidelines are all left to the responsibility of lower-level entities.

Lower-level government bodies, which may be a province, district, or municipality, play a crucial decision-making role in school SE in seven other countries. In general, the Ministry of Education is responsible for the first step, sometimes in close collaboration with a professional national entity such as a National Board (or 'Academy/Agency') of Education, as in Sweden, Finland, Ireland, and Kyrgyzstan. And sometimes the Ministry of Health collaborates with the Ministry of Education in SE programming.

Civil Society Partners

A wide variety of civil society organizations may influence the content and modes of delivery of SE. In many countries, the national IPPF member association (IPPF MA) is involved in the process. As mentioned before, IPPF MAs in the European Region are very active in promoting, delivering and improving school SE. In several countries, including Belgium, Bulgaria, Estonia, Finland, Spain and Sweden, the MAs have made major contributions to curriculum development, in addition to their role as being advocates for SE. Other civil society organizations that usually play a role, according to our respondents, are organizations of teachers and educationalists, and of health professionals. Religious groups or organizations are involved as well in several countries, particularly in Austria, the Czech Republic, England and Ireland, Latvia, the Russian Federation, and Switzerland. Involvement of a LGBTI group in developing or adapting an SE programme was only mentioned in one country: Estonia.

Only four countries in the assessment mentioned that young people were also involved in the practical development or adaptation of SE programmes: Belgium, Bosnia & Herzegovina, Ireland, and Sweden.

Similarly, parents play a more or less important role in it only in a minority of the countries, although a question on this possibility was explicitly included in the questionnaire. Active involvement of parents was mentioned in Austria, Belgium, Bosnia & Herzegovina, Kyrgyzstan, Latvia, Spain, and Ukraine.

UN Agencies

The UNFPA is an important support organization for SE. Because the work of UNFPA falls under 'development assistance', this UN agency is not active in about two-thirds of the countries in the region. However, it is still working in most South-Eastern European and Central Asian countries, and it supports or has supported the development of SE programmes in most of the countries in that part of the region. UNESCO, which is also active in this field, was only mentioned as an important partner in Tajikistan, but UNESCO does play an important role in informing governments on the benefits of SE in many more countries in Europe [1]. UNICEF does not appear to be closely involved in SE programmes *in schools*, but it initiates and supports out-of-school peer education programmes in some countries.

Position of SE in the Curriculum

SE programmes are almost always integrated into wider higher-level subjects. Stand-alone SE programmes are rare in the region. Spain is the only country in which SE is treated as a stand-alone subject. Although it is usually, but not always, addressed as a subtopic of 'health education', it is not integrated into it in the sense that the health education teacher deals with it. The teacher of the subject may, but does not have to, invite a specialized external agency to do a workshop on SE (original wording: 'affective-sexual education'). However, this is neither mandatory for all learners, nor are there specifications on what should be included. The latter depends very much on the type of organization that is invited, which may be a specialized SRH organization such as the IPPF member association, but can also be a religious organization.

With regard to the character of SE programmes, four groups of countries can be distinguished, although the boundaries between the groups are not rigid. The first group consists of countries that are classified as 'not providing SE', such as the Russian Federation or Serbia. In these countries, some basic information about the reproductive system is usually included in biology lessons, but 'sexuality'-related topics are not dealt with. Some

information may be provided on the need to prevent STIs and HIV infection (but not about the practice of how to do so).

There is a second group of countries in which SE is a subtopic of a (mandatory) 'healthy lifestyles education' curriculum – for example, in Kyrgyzstan and Tajikistan, or in Kazakhstan, where the topic is called 'valeology', i.e., the science of healthy living. In other countries, it only has a different name, such as 'basics of health' (Ukraine), simply 'health education' (Austria and Cyprus), or 'life skills and sexuality education' (Albania). In the Czech Republic, SE is part of the subject 'Human Beings and the World' in primary schools and 'Health Education' in secondary schools. In these countries, the focus tends to be on health issues and the need for prevention.

In the third group of countries, SE is also integrated into a broader subject, but the focus is not limited to health and also covers social, personal and interactive aspects of sexuality. This group includes countries such as England (where the title is 'SRE', i.e., sexual and relationships education), which is integrated into a wider subject called 'PSHE', meaning Personal, Social, Health and Economic education; in Ireland it is called 'SPHE' (Social, Personal and Health Education), and in Estonia PS&H (Personal, Social, and Health) education.

Finally, there is a fourth group in which parts of SE are integrated into a broad variety of other subjects, as for example in Germany (biology, ethics, religion, and social sciences), Bulgaria (civil, intercultural, health and environmental education), and the extreme case of Sweden (also called 'SRE'), where it can be part of eight different framework subjects. To this already complex picture, it should be added that the physiology of reproduction, sometimes including contraception, is in most cases dealt with under biology.

Training of Teachers in Sexuality Education

Training of teachers in delivering a SE programme is the weak link in many countries. It is only in a handful of countries (notably Finland and Estonia) that teacher training in SE has been institutionalized to such extent that it has become part of the curriculum of teacher-training colleges

and universities that prepare future teachers. In most other countries, teachers are trained in special in-service courses, but usually, only a (small) selection of teachers participates in such courses. Large numbers of teachers have been trained in such courses only in a few countries, such as Albania and the canton of Sarajevo, mainly because the teacher training was or is part of a comprehensive programme of introducing SE as a new curriculum subject.

In many other countries, hardly any teachers have been trained – which is a serious shortcoming, since teaching SE requires familiarity with various interactive teaching methods, and ability to handle active participation on the part of learners and special skills in discussing sensitive issues. Most teachers have never practiced these approaches and methods. For this reason, the BZgA has recently brought out a training framework for SE teachers that indicates which competences SE teachers should master in order to become successful SE teachers [5].

Monitoring and Evaluation (M&E)

The implementation of SE is periodically monitored and sometimes even evaluated in only eight countries out of 21 that have a SE programme. In four other countries, only some aspects are monitored, and in another eight countries, there is no M&E at all. An example of the evaluation of teacher training, as part of an overall evaluation process during the pilot phase of the programme, is the case of Albania. This evaluation, supported by the IPPF EN, was implemented in four schools in two of the country's cities. The results showed that teachers were better prepared to teach the subject and that the training was evaluated as 'very satisfactory'.

It should be emphasized in this context that SE is almost never an examinable subject, and assessments of SE during a school year are therefore also rare. Most often, M&E is only given more than marginal attention during the developmental phase of an SE programme, when there is a need to evaluate the results of a pilot project. In these cases, it serves the clear purpose of identifying where a draft programme needs to be adapted and improved before it is finalized.

How Important Is the Role of Schools as a Source of Information about Sexuality?

Respondents were asked if there had been any recent survey results indicating the importance of SE as a source of information for young people on sexuality-related issues. Such survey results were available in 14 of the 25 countries. The results should be treated with caution, as they are not always internationally comparable because the age groups in the samples differ; questions were asked differently, or for other reasons.

In Estonia, for example, where 97% of 16–17-year-olds received sexuality education in school, the results are very different depending on the age group of the respondents in the survey [13]: among 16–17-year-old girls, 76% felt they had had sufficient (or even too much) discussion in school on sexuality-related topics; among 18–24-year-olds, the figure was 70%; and among 25–34-year-olds, it was only 48%. The increase with decreasing age probably indicates the gradual improvement and wider coverage of SE in Estonia between 2000 and 2014.

School SE is also an important source of information on sexuality-related topics in Belgium, Austria, Germany, and the Netherlands – countries with fully comprehensive programmes (mentioned by more than 80% of young respondents). In three other countries, around 50% mentioned the school as an important source of sexual knowledge: England, Sweden, and Kazakhstan.

In the remaining six countries with recent data, the school as a source of information about sexuality was mentioned by one in three respondents or less: Ukraine (33%), Bulgaria (25%), Spain (22%), Kyrgyzstan (18%), Georgia (10%), and finally Macedonia FYR (2%). These are countries in which SE is not yet fully developed and not mandatory, or even as yet non-existent. In this last group of countries, most young people rely almost exclusively on friends and peers, and on the Internet and social media, as information sources. The role of parents in educating their children on sexuality-related issues is usually more marginal in these countries than in those in which school SE is fully developed. In other words, it appears that

high-quality SE programmes do not replace parental responsibility, but instead complement it.

Sexuality Education Outside School

In this section, we present interesting and relevant examples of out-of-school programmes in the 25 countries. This is based on the responses to the questionnaire and is not intended to be an exhaustive list of out-of-school activities in the field of SE.

In all countries in the European Region, activities are carried out to teach young people who are not attending school about sexuality-related issues. In some countries, such as Germany, such activities are multi-dimensional and extensive.

In countries in which the large majority of young people, up to the age of 16–18 years are in school and receive SE there, out-of-school activities are mostly directed at young people who are vulnerable and most at risk, in many cases not attending regular schools. This includes young people with physical or learning disabilities, those who live in special care or correctional institutions, and those who are especially at risk for HIV, STIs, unwanted pregnancy, or sexual abuse and violence for behavioural reasons, or because they are marginalized.

Examples are young people who use intravenous drugs, young men who have sex with men (MSM), young sex workers, new immigrants, refugees and ethnic minority groups, such as Roma people. The sexual and reproductive health needs of these vulnerable groups are, as far as possible, met through special service centers and outreach work, offering SRH services as well as various educational activities. Many of these support activities are implemented by NGOs, including the member associations of IPPF, some of which offer specialized services to specific vulnerable groups of young people. If available, organizations use their clinics or centers to provide a combination of youth-friendly SRH services and information/education. In the low-income or middle-income countries in the region, which is particularly located in South-Eastern Europe and

Central Asia, international agencies such as the UNFPA, UNICEF, and UNESCO often provide support for those initiatives. In quite a few countries, there are also peer education activities.

Organizations working in this field also usually make extensive use of the new digital media. On their websites and through social media, they try to raise awareness and provide information about various aspects of youth sexuality and prevention of possible (health) problems related to risky sexual behaviour. It is often difficult to assess how many young people are reached in these ways and how effective the activities are. A few interesting examples of the kind of activities that have been developed and implemented are given below. This brief overview is not exhaustive.

General and Topic-Specific Websites

In Bulgaria, different NGOs operate websites with general SRH information, such as the platform 'Loveguide.bg' and the website 'Safesex.bg' of the BFPA (an IPPF member association). In addition, attention is given to the educational needs of various vulnerable young people and groups at risk. The BFPA has developed guidelines for young people with disabilities and, in collaboration with the National Network of Health Mediators, it has developed guidelines for working with young Roma. As part of a Global Fund programme, other NGOs have developed guidelines for working with people who inject drugs and young LGBT people.

In Germany, educational activities take place via the BZgA website 'LOVELINE.DE' and the 'SEXTRA.DE' site run by pro-famila (an IPPF member association), as well as through social media and via youth magazines. Both organizations and several other NGOs also focus on specific groups. For example, the German 'AIDS Help' ('Deutsche AIDS Hilfe', DAH) is actively working with young LGBTI people (lesbian, gay, bisexual, transgender, and intersex). There are information materials for young drug users (print and digital) to prevent STIs and SE programmes for young people with disabilities. Information materials (print and digital) are available in many languages.

In the Russian Federation and Ukraine, among other countries, UNESCO has provided active support for the website TEENSLIVE.INFO that has recently been developed to provide adolescents in Eastern Europe and Central Asia, including Russia and Ukraine, with comprehensive information about sexual and reproductive health.

Finally, in Austria, the IPPF member ÖGF has introduced an online SRH counseling service for young people. For five Balkan countries, including Bosnia and Herzegovina, there is also a sex-positive website (Pazi Sex) that provides learning opportunities and counseling services.

In addition to the official websites of formal organizations working in the field of SE, blogs and other social media activities (such as YouTube channels) run by many individuals in different countries become more and more relevant in the lives of young people. Through different channels and formats, bloggers and vloggers are using the Internet to educate others about various sexuality-related topics.

General Population: Radio and TV Programmes

Since the advent of the Internet and social media, the traditional mass media, radio, and TV have become somewhat less important for education on healthy lifestyles and sexuality. Probably the very first SE programme on TV dates back to 1974 when in the Netherlands the educational TV series ‘Open en Bloot’ (Open and Naked) was broadcast – revolutionary at that time. In the same country, an educational TV programme called ‘Dr. Corrie’ started in 2016 with weekly 20-minute episodes, discussing 20 different topics during the same number of weeks. The programmes were watched by 200,000 (mainly) young learners aged 10–14.

In Ukraine, local TV and radio companies sometimes also broadcast a series of thematic episodes with the participation of medical staff and representatives of NGOs working in the field of SRHR. In Spain, there are radio and TV SE programmes, such as those developed by the Amaltea organization, and in Macedonia FYR there is a ‘Sexy Hood’ radio show on various sexuality issues.

Young People with Physical or Learning Disabilities

In several countries, tailored SE programmes have been developed for young people with physical or learning disabilities. In Germany, a video film has been produced, commissioned by pro-famila in cooperation with Aktion Mensch, called 'Liebe und so Sachen' (Love and Things Like That) for young people with disabilities and for their teachers. An educational handbook is included for using the video.

In England, the FPA (an IPPF member association) is working directly with people with learning disabilities in schools and other settings. Its project in the London Borough of Westminster offers sex and relationships education and training to people with learning disabilities from age 14. They support staff members who work with these young people, their parents and carers at schools, colleges, day centers, and homes.

In Bulgaria, attention is also being given to the educational needs of various vulnerable young people and groups at risk. The BFPA has developed guidelines for young people with disabilities. In Latvia, the IPPF member, Papardes zieds, has developed SE training for teachers and other people working with young people living with learning disabilities. Finally, in the Netherlands a special website is available, 'Leerlijn' (Learning Line) for educating young learners with disabilities on sexuality-related issues.

Young Refugees, Migrants, and Other Minority Groups

In Austria, two collaborating organizations, 'FEM/MEN' and ÖGF (an IPPF member), offer workshops free of charge for undocumented migrants, refugees who are unaccompanied minors and other vulnerable groups, always facilitated by one male and one female expert, implemented in an age-appropriate manner. In Germany, there are also special programmes for young refugees.

In the Flemish part of Belgium, the IPPF member organization Sensoa has developed the website 'Zanzu' jointly with the BZgA. The website is especially relevant for the many immigrants who have not yet mastered the national languages (French and Flemish). Zanzu covers just about anything related to sexual health, using many icons and pictures. There is very little

text, but one can choose one of no less than 14 languages. There are chapters on the human body, family planning, and pregnancy, sexuality, STIs, etc. The evaluation of Zanzu in 2016 shows that the website meets the needs of professionals who provide SE for immigrants [14].

The BFPA (the IPPF member in Bulgaria) and the National Network of Health Mediators have developed guidelines for working with young Roma. As part of a Global Fund programme, HERA (an IPPF member) is providing education for Roma in Macedonia FYR through its youth-friendly centers and by using peer education. In Serbia, 'SRH Serbia' also provides non-formal peer (sexuality) education through the project 'Drop-In Centre for Human Rights', reaching various vulnerable groups, among them young Roma people. In several countries, including Austria, Sweden, Belgium, the Netherlands and Spain, programmes are running that focus especially on migrants.

Peer Education

Peer education programmes are being implemented mostly in the countries of South-Eastern Europe and Central Asia. There are probably two reasons why this approach is popular in this part of the region. Firstly, in most of these countries, formal in-school SE is still quite rare, although such programmes are being developed in some of them. This factor stimulates out-of-school educational activities, like peer education. Secondly, the UNFPA is still active in this part of the region (and not in Western Europe) and it actively supports peer education. It has created an international Y-PEER network that supports peer education in different countries. Some of these programmes have already been implemented for quite a long time. In Kyrgyzstan, for example, a training-of-trainers project among youth and adolescents based on the 'peer to peer' principle covering almost all regions of the country has a long history, dating back to 2001. It has been successfully promoted by several NGOs and provides coverage of youth from different groups in non-formal educational settings. Similar programmes are being implemented in Kazakhstan and Tajikistan.

The IPPF member SRH Serbia also provides non-formal peer (sexuality) education through the project 'Drop-In Centre for Human Rights', reaching various vulnerable groups. In a few Central and Western European countries as well, however, there are also peer education programmes – as in England, Switzerland and the Czech Republic. And in Estonia (where a comprehensive SE programme has been implemented in all schools) and Belgium, peer education programmes are nevertheless organized by the Medical Students Association.

Other Initiatives

In some of the countries, innovative approaches have been developed for improving out-of-school SE or for reaching new objectives. Some good examples of this are:

For teacher training colleges in the Netherlands, two lesson packages have been developed to train teachers in delivering SE: 'Over seks gesproken!' (Let's talk about sex!) for primary school teachers, and 'Juf, doet u ook aan seks?' (Miss, do you also do sex?) for training new biology teachers for secondary schools.

'Get going: my strengths, my future' (www.komm-auf-Tour.de) is an interactive carers advice and life planning service for young people in Germany. It provides new, activity-based incentives for supporting schoolchildren in the seventh and eighth grades of secondary school in discovering 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.

The IFPA (an IPPF member in Ireland) and the British FPA run programmes called 'Speakeasy' that are designed to provide parents, guardians, and carers with the information, skills, and confidence needed to talk to their children openly about relationships, sexuality and keeping safe.

Finally, the 'Flag system' (Vlaggensysteem) programme developed by Sensoa in Belgium is notable. It consists of a guidance document facilitating discussion on boundaries regarding sexual behaviour within the school system and other settings where young people are active.

Youth-Friendly SRH Service Delivery

Young people in need of SRH services often face barriers to attending these services, for a variety of reasons. Many attempts have been made around the world to make SRH service delivery more 'youth-friendly', either by making adult services more youth-friendly or by creating separate clinics or centers, especially for young people. International expert organizations have developed models and guidelines for this purpose [21, 22, 23, 24]. Conditions that make services youth-friendly include at least the following:

- Staff members know how to communicate with young people in a respectful and nonjudgmental manner.
- There are strict rules about confidentiality and privacy for young people.
- Opening hours are convenient and the facility provides a non-threatening environment for young people.
- Services are free of charge or at least affordable for young people.
- Young people participate in developing policies and implementing services.

SRH service delivery centers or clinics that mostly or entirely focus on serving young people are available in the vast majority of countries (20 out of 25). In half of these countries, they are widely available, and in the other half, there are only a few of them. Five countries do not have such services at all, and it is quite remarkable that there are at least two countries where one would expect them – the Netherlands and Switzerland. In the Netherlands, there was indeed an extensive network of independent youth-friendly SRH service centers from the 1960s until the 1990s, but all of these centers were ultimately closed as the demand for their services rapidly declined because their function had been taken over by family doctors. This could only happen because the taboo on adolescent sexuality largely disappeared and adolescent sexual behaviour became generally accepted. In this changing socio-cultural context, adolescents no longer felt

any need for a separate service. The family doctor was simply closer and easier.[34] At the other extreme, Georgia is a clear case of a country where (premarital) sexual behaviour in adolescent girls is strongly culturally prohibited. Between 2006 and 2009, several youth-friendly SRH centers were created, as part of a large internationally supported youth SRH project. However, it soon turned out that these centers were hardly being used and were therefore not sustainable. One of the main reasons for this was that girls hardly dared to use the services or be seen in such a center. It would have been interpreted as meaning they were having a sexual relationship, which is still very unacceptable culturally. All of the centers were therefore gradually closed after 2009.[35]

The WHO [21] has indicated that young people not only need information and education, as in the form of school SE, but at the same time services for them should be available, affordable and acceptable, and they should know where to find such services. It is therefore important for attention to be given to youth-friendly SRH services in SE lessons.

In practice, the assessment indicates that in slightly less than half of the countries, there are clear linkages between SE and youth-friendly SRH services. Those linkages most often mean that information about the services is provided during SE lessons. It can also mean that the staff of youth-friendly SRH services give some SE lessons in schools. Finally, in some countries (Sweden and Estonia, for example) school classes regularly visit these youth clinics and receive lessons there, which has the additional advantage that learners become familiar with a clinic, thereby potentially reducing the threshold of attending it when they need services later on.

Table 2 provides a systematic overview related to SRH services for young people and some immediately related issues that were included in the questionnaire for the assessment.

There is a mixed picture in Europe with regard to free-of-charge or paid-for youth SRH services. In half of the countries, (most) SRH services

[34] Personal information from E. Ketting, a former board member of 'Rutgers Stichting', the NGO that was running these youth-friendly clinics.

[35] Result of an evaluation mission conducted by E. Ketting in 2016 on behalf of the UNFPA national office for Georgia.

are free of charge for young people.– or they only have to pay for particular services and not for others.

Table 2. Core data on availability and accessibility of SRH services for young people

Country	Availability of YFS[1]	Payment for SRH services[2]	Payment for contraception[3]	EC availability[4]	Age of consent (year) for abortion & contraception[5]
Albania	Few	No	No	Yes	A:16 C:No
Austria	Widely	No	Yes	Yes	A:14 C:14
Belgium (Flanders)	Widely	Partly	Partly	Yes	A:No C:No
Bosnia & Herzegovina*	Few	Partly	Yes	No	A:18 C:18
Bulgaria	Few	Partly	Yes	Yes	A:18 C:14
Cyprus	No	Yes	Yes	Yes	A:17 C:17
Czech Republic	Few	No	Yes	Yes	A:15 C:15
England	Widely	No	No	Yes	A:No C:No
Estonia	Widely	Partly	Yes	Yes	A:No C:No
Finland	Widely	No	Yes	Yes	A:No C:No
Germany	Widely	No	No	Yes >13y	A:14 C:14
Georgia	Few	Yes	Yes	Yes	A:18 C:14
Ireland	Few	Yes	Yes	Yes >15y	A:16 C:16
Kazakhstan	Widely	No	Yes	No	A:18 C:16
Kyrgyzstan	No	Yes	Yes	Yes	A:16 C:No
Latvia	No	Partly	Yes	Yes	A:16 C:16
Macedonia FYR	Few	Partly	Yes	No	A:18 C:No
Netherlands	No	Partly	Partly	Yes	A:16 C:No
Russian Federation	Widely	No	Partly	Yes >16y	A:15 C:No
Serbia	Few	No	Yes	Yes	A:16 C:No
Spain	Few	No	Partly	Yes >15y	A:18 C:16
Sweden	Widely	No	Yes	Yes	A:No C:No
Switzerland	No	No	Yes	Yes	A:No C:No
Tajikistan	Widely	No	Partly	Yes	A:18 C:15
Ukraine	Few	No	Yes	Yes	A:14 C:14

* Canton of 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 (EC) available for young people without a doctor's prescription?

[5] What is the age of consent?: A = for abortion; C = for contraception. No = No age of consent.

Sometimes this is because SRH services are free of charge for the entire population, but in other cases, there are special arrangements for young people up to a certain age. In a quarter of the countries, only some young people have to pay for services – for example, because they are above a certain age There are only three countries in the sample (Albania, England, and Germany) in which contraceptives can be obtained for free by young people. In all the other countries, they have to pay for them – sometimes at a reduced price because there is a special subsidy programme for young people. Several respondents from low-income and middle-income countries reported that the price of contraceptives is often a barrier for young people. This outcome confirms the results of an IPPF EN study on access to modern contraceptives in Eastern Europe and Central Asia [25]. In almost all countries, young people have to pay for abortion.

In 2015, the European Commission issued a binding decision that emergency contraception (EC) should be available without a medical prescription, amending the marketing authorization granted in 2009 [15]. Since then, EC can now simply be bought, without medical prescription, in pharmacies or drugstores in (almost) the entire European Union. A lower age limit for buying contraceptives still applies in only a few countries (Germany, Ireland and Spain). EC is not available without a medical prescription in only three non-EU countries in the sample (Bosnia & Herzegovina, Macedonia FYR, and Kazakhstan).

In less than half of the countries, adolescents may have a problem in obtaining medical (prescription) contraceptives (in practice, mainly the pill and the IUD) because there is a legal age of consent for it, meaning that approval from a parent or guardian is needed. However, this is mostly a problem for very young adolescents, as the age of consent is usually 16 years or even younger. It is only in Bosnia & Herzegovina and Cyprus that the age of consent is higher (18 and 17 years, respectively).

In reality, the vast majority of sexually active young adolescents use condoms (see Table 4 below), if they use any method, and condoms are openly for sale in several places in all the countries. The age of consent for deciding on an abortion, without parental consent, is a real obstacle for young people. In a quarter of the countries surveyed, all young people can

decide on this without permission from a parent. In 10 countries, they can do so from age 16 on, or even younger. Abortion under the age of 16 is quite rare in Europe. The age of consent for abortion is 17 or 18 years in only seven countries (see Table 2). It should be added to this that in several countries, girls under the legal age of consent can decide on abortion if the doctor's judgment is that they are mature enough to take the decision.

Demographic Data on Adolescent SRH

Table 3 presents an overview of the core demographic data that are relevant in relation to adolescent sexual behaviour and SE. Because births in teenage girls are usually unplanned and often unwanted, this is an often-used indicator of the status of adolescent SRH in a country. The teenage abortion rate is not included, as these data are often (very) incomplete at the country level in Europe. For this reason, the WHO and the Guttmacher Institute in New York recently started to present these data only at the regional and sub-regional level, based on an estimation model [16].

Teenage Birth Rate

Table 3 shows that there are huge differences in the teenage birth rates, ranging from as low as three per 1,000 girls aged 15–19 years in Switzerland to a high 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 England and the rest of the UK, the rate is still relatively high in comparison with other Western European countries, although it has been reduced by half during the past two decades. Cyprus, with a very low teenage birth rate for which there is no immediate explanation, 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.

Table 3. Total population, population aged 15–19 years, teenage birth rate and trends in teenage birth rate relative to the comprehensiveness of the SE programme in 25 European Region countries (latest available comparative data)

Country	Total population × 1,000	Population aged 15–19 × 1,000	% aged 15–19 in total population	Births per 1,000 women 15–19 y	
				Abs.	Trend[1]
Fully comprehensive programmes					
Albania	2,896	257	8.9%	22	+
Austria	8,508	470	5.5%	7	– – –
Belgium	11,204	631	5.6%	8	– –
Bosnia & Herzegovina	3,843	279	7.3%	8	– – –
Estonia	1,313	60	4.6%	12	– – –
Finland	5,451	313	5.6%	6	– –
Germany	80,767	4,054	5.0%	6	– – –
Netherlands	16,829	996	5.9%	4	– – –
Sweden	9,645	544	5.6%	6	–
Switzerland	8,238	439	5.3%	3	– – –
Median				6.5	
Partly comprehensive programmes					
Cyprus	840	56	6.6%	5	– – –
Czech Republic	10,539	463	4.4%	10	– –
Kyrgyzstan	5,957	520	8.7%	39	– –
Median				10	
Non-comprehensive programmes					
England (= UK data)	64,308	3,864	6.0%	14	– – –
Ireland	4,635	283	6.1%	10	– –
Kazakhstan	17,161	1,229	7.2%	27	–
Latvia	1,994	90	4.5%	13	– –
Russian Federation	143,202	7,392	5.2%	23	– –
Spain	46,512	2,140	5.1%	8	–
Tajikistan	8,074	863	10.7%	38	–
Ukraine	45,309	2,405	5.3%	23	– –
Median				18.5	
Not available					
Bulgaria	7,246	319	4.4%	37	–
Georgia	4,490	273	6.1%	38	– –
Macedonia FYR	2,066	137	6.6%	17	– –
Serbia	7,147	375	5.3%	19	– –
Median				28	

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.

The introduction of a comprehensive school SE programme is not related to this, because it occurred very recently and is still in the process of being rolled out nationally. The latest available data for Georgia (not included in the table) also show an upward trend from 40 per 1,000 girls aged 15–19 years in the year 2000 to 51.5 in 2014.[36]

In general, there has been a rapid decline (indicated as '– – –') in the teenage birth rate in countries in which the rate was already fairly low, and a slower decline or no decline at all in countries where it was and still is high.

Finally, the teenage birth rate correlates negatively with the comprehensiveness of SE: the rate is low or very low where national comprehensive SE programmes are in place, and high or very high in countries in which SE programmes are still at an early stage of development. However, caution should be exercised in drawing any causal conclusions regarding the relation between comprehensive SE and teenage pregnancy (or sexual behaviour, for that matter), since low teenage pregnancy rates are equally influenced by other factors such as societal acceptance of adolescent sexuality and access to contraception.

Sexual Behaviour of 15-Year-Old Boys and Girls

There is only one source that includes internationally comparative data on adolescent sexual behaviour for a large number of countries in Europe: the 'Health Behaviour in School-aged Children' (HBSC) study by the European Regional Office of WHO [17]. Because the same questions are asked in all participating countries, the results are internationally comparable. The study was started in 1993–94 and is repeated every four years. The latest survey was done in 2014–15, and the international report on it was published in 2016. The survey includes three questions on sexual behaviour put to the 15-year-olds:

[36] National Centre for Disease Control and Public Health, *Health Care; Statistical Yearbook 2014 Georgia* (Tbilisi: Ministry of Labour, Health and Social Affairs, 2015). Note that these data are more recent than those presented in Table 3.

1. Have you ever had sexual intercourse?
2. Did you use a condom at the last intercourse?
3. Were you using the pill at the last intercourse?

Table 4. Sexual and contraceptive behaviour of 15-year-old boys and girls in Europe

Country	**Sexual experience (ever)**			**Condom use (last)**			**Pill use (last)**		
	Boys	Girls	B+G*	Boys	Girls	B+G*	Boys	Girls	B+G*
Fully comprehensive programmes									
Albania	39%	2%	20%	63%	38%	50%	19%	7%	13%
Austria	24%	20%	22%	77%	74%	75%	57%	43%	50%
Belgium (Flanders)	20%	18%	19%	64%	52%	58%	60%	68%	64%
Estonia	20%	21%	20%	72%	71%	71%	19%	13%	16%
Finland	25%	24%	24%	73%	57%	65%	30%	40%	35%
Germany	22%	19%	20%	72%	67%	69%	69%	62%	65%
Netherlands	15%	16%	15%	78%	65%	71%	60%	66%	63%
Sweden	24%	26%	25%	61%	47%	54%	32%	32%	32%
Switzerland	17%	13%	15%	82%	80%	81%	35%	36%	35%
Average	23%	18%	20%	71%	61%	66%	42%	41%	41%
Partly comprehensive programmes									
Czech Republic	23%	24%	23%	74%	66%	70%	29%	30%	29%
Non-comprehensive programmes									
England	18%	23%	20%	62%	57%	59%	32%	33%	32%
Ireland	21%	14%	17%	64%	65%	64%	23%	25%	24%
Latvia	22%	14%	18%	71%	69%	70%	9%	9%	9%
Russian Federation	26%	11%	18%	67%	67%	67%	-	-	-
Spain	24%	19%	21%	63%	77%	70%	10%	14%	12%
Ukraine	24%	9%	17%	80%	73%	76%	17%	13%	15%
Average	23%	16%	19%	68%	68%	68%	19%	19%	18%
Not available									
Bulgaria	40%	21%	30%	66%	56%	61%	18%	6%	12%
Macedonia FYR	36%	3%	19%	64%	48%	56%	29%	15%	22%
Average for 18 countries	**24%**	**17%**	**20%**	**70%**	**63%**	**66%**	**32%**	**30%**	**31%**

* Boys and girls together.

Source: HBSC (2016). Averages for boys + girls were added (rounded off downwards). Reference: WHO Regional Office for Europe (2016).

Seven of the 25 countries in the survey were not (yet) participating in the latest HBSC survey: Bosnia & Herzegovina, Serbia, Cyprus, Georgia, Kazakhstan, Kyrgyzstan and Tajikistan. Table 4 provides an overview of the sexual behaviour results from the latest HBSC survey (2016) of the 18 countries that participated in the survey.

The *average percentages* for boys and girls together have been added to this overview. This is because in countries with a dominant 'double standard',[37] there is a strong tendency among boys to over-report and girls to under-report their sexual experience. The combined data are therefore a better indicator of sexual behaviour in this age group.

The results show that about one in five 15-year-old adolescents have ever had sexual intercourse, with a range between a low 15% in the Netherlands[38] and Switzerland and a high of 30% in Bulgaria. Half of the 18 countries in Table 4 (i.e., nine countries) have a fully comprehensive SE programme, and the other half do not. There is no significant difference between the two groups in the percentage of 15-year-olds who have experience with sexual intercourse (20.0% in the first group and 20.3% in the second). The conclusion should be that the data do not indicate that having a comprehensive SE programme is associated with an earlier start of sexual intercourse.

In all countries, half or more of the adolescents who have experience with sexual intercourse reported that they (or their partner) had used a condom at their last intercourse, varying between a low 50% in Albania and a high 81% in Switzerland. On average, about two-thirds of them used a condom. There is no clear sub-regional pattern in the level of condom use, in terms of north–south or east–west differences. The relatively high rates of condom use probably indicate that condoms are easily available as well as affordable in almost all European countries. The survey data more or less confirm this.

[37] 'Double standard' means that boys are generally allowed or even encouraged to have sexual relationships, whereas girls are not (at all) permitted to have them.

[38] The initial results of a representative survey among 12–24-year-olds, which became available in June 2017, indicate that this low percentage has declined even further (reference 18).

Use of Oral Contraception

Usage of oral contraception ('the pill') shows much more variation across Europe. On average, just over a quarter of 15-year-old girls (or the female partners of boys) 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, England and the Czech Republic. Pill use is quite rare in this age group in Southern and Eastern European countries, as well as in the Baltic States. This might be the result of a lack of reliable knowledge about the method, poor accessibility of services, or prices being scarcely affordable for adolescents.

In several countries, the total reported percentages of condom + pill use at last intercourse are above 100%. This indicates that many adolescents use both methods at the same time, a practice that is often called 'double Dutch'. 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 and comprehensive SE programmes. Countries with high teenage birth rates tend to have a low combined rate of condom + pill use.

CONCLUSIONS

This chapter has provided an overview of the current status of SE in the WHO European Region (Europe and Central Asia). It is the most comprehensive assessment of SE in this region that has so far been conducted, and valuable lessons can be learned. Before moving on to the core conclusions of this assessment, two limitations of the study should be mentioned. Firstly, while the assessment was the most thorough to date, it is based on two respondents per country. While these respondents were carefully selected and were experts in the field, it is possible that other respondents might have provided additional information. Secondly, while the assessment comprehensively inquired into numerous aspects of SE, it

was not able to study on the ground what is actually being taught in the schools.

Conclusion One

Since the year 2000, rapid progress has been made in developing and integrating SE into formal school settings in Europe and Central Asia.

- There is currently a legal basis for SE in 18 out of 25 countries in this survey. In half of the remaining countries, ongoing meaningful initiatives are currently taking place to develop school SE.
- In 10 of the 25 countries in the assessment, the SE programme has a clearly comprehensive character, and in four more countries the programme is tending to become more comprehensive. In the remaining countries, SE either hardly exists at all or focuses primarily on biological aspects.

Conclusion Two

Although SE varies widely across the region, it also has remarkable common characteristics.

- SE in the European region is almost always integrated in wider teaching subjects, such as biology, life skills, or health education; stand-alone programmes are rare.
- In descending order, topics in SE 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 given to love, marriage and partnership; gender roles; mutual consent to sexual contacts; sexuality and online media; and human rights and sexuality. Access to abortion;

sexual abuse; domestic violence; and sexual pleasure in particular are addressed only sporadically.

- In 11 of the 25 countries, the school SE programme is mandatory; in seven countries, it is partly mandatory – i.e., not in all schools; and it is optional, i.e., *can* be chosen, in only four countries.

Conclusion Three

School-based SE programmes exist in a social context in which 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 SE. The main argument against it – i.e., '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 SE, young people tend to start with sexual contacts later.
- In all countries in the European Region, activities are being undertaken to teach young people out of school about sexuality-related issues. These activities mostly involve targeting vulnerable, marginalised, and high-risk young people. In several countries, these groups are reached by means of peer education.
- In about 80% of the countries in the European Region, special youth-friendly SRH service centers or clinics are available, although in several countries their number is insufficient to meet the needs of all young people. However, in countries in which these special services are not available, adolescent sexual health indicators are not generally worse. In some countries, the reason for this seems to be that adult services are sufficiently accessible and acceptable for young people.

Conclusion Four

Comprehensive SE programmes correlate with positive adolescent SRH indicators. Nevertheless, other influencing or intermediate factors may be responsible for such correlations.

- Since the year 2000, teenage birth rates have been showing a declining trend in all except one country in the region, particularly in countries in which the 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 three per 1,000 15–19-year-old girls in Switzerland and a high 39 per 1,000 in Kyrgyzstan.
- In countries with fully developed comprehensive SE programmes, young people tend to mention the school in particular as an important source of information about sexuality.
- In countries in which SE is hardly taught in schools, or not at all, teenage birth rates tend to be high. In these 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 the age of 15. While there are some 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

Recommendation One

Knowledge and experience in developing and implementing school-based SE programmes should be much more shared internationally.

- Knowledge about and practical experience with SE in many countries in the European Region are much more developed than in other regions of the world, but this is scarcely reflected in the international literature. More studies from the region in the field of SE should therefore be initiated and published in international journals and shared with international expert organizations working in the field.
- Direct sharing of knowledge and experience and collaboration in the field of SE should be strengthened at the European level. There are several countries in Europe that have useful experience in it, and there are new and innovative initiatives in developing and running SE programmes throughout the entire European Region. This experience should be shared with countries that are just starting to develop SE or want to improve their programmes. In addition, internationally agreed strategies and action plans, such as the WHO Action Plan for SRHR [19], can provide an additional and useful basis for the development of policies and programmes.

Recommendation Two

The quality of SE programmes needs to be improved by starting SE in learners at a young age, increasing their involvement in it, broadening the range of topics addressed and improving teacher training and support.

- In several European countries, SE starts in primary (or elementary) school, where it tends to focus on information about the human body, its functions and changes during puberty, and on human relationships. It is essential that this information should be provided at a relatively young age and that it should precede education about having sexual contacts and issues directly related to that (i.e., contraception or prevention of STIs).
- Scientific evidence of the positive impact of SE on young people's health and well-being and of the conditions that contribute to its

positive impact is widely available [6]. However, far less is known about the way in which SE is perceived and appreciated by learners. For this reason, there is a need for a shift of attention in evaluation studies [4]. Core questions that should be addressed in evaluation research are: Does SE really respond to the needs and interests of learners, and what do they miss? Do they feel the teaching is understandable, useful and applicable in their personal lives? Which teaching methods are most appreciated by learners? Do learners feel they are sufficiently involved in the teaching process? It is also essential for young people to become much more involved in the development, implementation and evaluation of SE programmes.

- In the vast majority of countries in the WHO European Region, there is a clear need to train teachers in SE and to develop educational materials for this purpose. Training of future teachers in SE has been included in the training curricula of teacher training colleges and universities in only a handful of countries in the region. The same should be done in all other countries in which SE is mandatory or optional. The WHO/BZgA 'Standards for Sexuality Education in Europe' [2] and the publication 'Training Matters: a Framework for Core Competencies of Sexuality Educators' [5] may be useful for this purpose.
- Because several SE programmes are still tending to focus primarily or almost exclusively on biological aspects of reproduction and on the prevention of HIV/STIs and unwanted pregnancy, there is a need to broaden the range of topics that are addressed. Important other topics that should be dealt with are: gender equity; mutual consent to sexual contacts; sexuality on the Internet and social media; human rights and sexuality, and particularly also access to abortion; sexual abuse; and sexual pleasure.

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