


CONDENSED EDITION



INTERNATIONAL TECHNICAL AND PROGRAMMATIC GUIDANCE ON  
**OUT-OF-SCHOOL COMPREHENSIVE  
SEXUALITY EDUCATION**

AN EVIDENCE-INFORMED APPROACH  
FOR NON-FORMAL, OUT-OF-SCHOOL PROGRAMMES





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**SEXUALITY EDUCATION**

An evidence-informed approach  
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## Foreword

The world today is home to one of the largest generations of young people in history. By investing in their health and education, governments can support young people's engagement in society, ensure their well-being, and help them achieve their full potential. Positioned at the crossroads of education and health, comprehensive sexuality education (CSE) is vital to advancing health outcomes and gender equality. It gives young people the tools they need to have healthy lives and relationships, and helps them navigate life-changing decisions about their sexual and reproductive health.

Yet, many young people receive a range of scientifically incorrect, conflicting and confusing messages about sexuality and gender on a daily basis. This can lead to serious risks for their health, well-being and dignity. As a result, poor sexual and reproductive health outcomes are a reality for many young people today. This points to the urgent need for effective CSE on a large scale. Published by UNFPA, together with contributing agencies UNESCO, UNICEF, UNAIDS and WHO, the *International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education* is an indication of our joint commitment to this work.

It comes amid growing momentum for CSE globally, and coincides with UNFPA's 50th anniversary and the 25th anniversary of the International Conference on Population and Development and its groundbreaking Programme of Action. It also supports the implementation of the 2030 Agenda for Sustainable Development, which aims to reach those furthest behind, including young people, people with disabilities, those living with HIV, Indigenous communities, refugees and migrants. Because many among these groups are not in school, and those attending school may not receive CSE, out-of-school programmes can help fill the gaps and effectively address their needs.

This Guidance complements and refers to the *International Technical Guidance on Sexuality Education* published in 2018. Informed by evidence and grounded in a human-rights approach, this out-of-school edition provides concrete guidelines and recommendations to ensure that the most vulnerable young people receive information that enables them to develop the knowledge and skills they need to make informed choices about their sexual and reproductive health.

Along with our contributing partners, UNESCO, UNICEF, UNAIDS and WHO, we at UNFPA urge programme developers to apply these comprehensive guidelines to promote the empowerment, self-determination and health of young people who are at highest risk for negative outcomes. This includes those facing violence and discrimination, marginalization, poverty, HIV and other sexually transmitted infections, and mental-health problems, among other issues. We are committed to reinforcing and promoting the universal values espoused in this Guidance, including gender equality, dignity, social inclusion and human rights for all.

We will continue our efforts until every young person has the knowledge to live a healthy life, the opportunity to reach their full potential, and the space to contribute to building a better future for all.

Dr Natalia Kanem  
*UNFPA Executive Director*

## Acronyms and abbreviations

<b>AIDS</b>	acquired immunodeficiency syndrome	<b>UN</b>	United Nations
<b>APCOM</b>	Asia Pacific Coalition on Male Sexual Health	<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>APN+</b>	Asia Pacific Network of People Living with HIV/AIDS	<b>UNDP</b>	United Nations Development Programme
<b>CSE</b>	comprehensive sexuality education	<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>GNP+</b>	Global Network of People Living with HIV/AIDS	<b>UNFPA</b>	United Nations Population Fund
<b>HIV</b>	human immunodeficiency virus	<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>INPUD</b>	International Network of People who Use Drugs	<b>UNICEF</b>	United Nations Children’s Fund
<b>IPPF</b>	International Planned Parenthood Federation	<b>UNODC</b>	United Nations Office on Drugs and Crime
<b>IRC</b>	International Rescue Committee	<b>UN Women</b>	United Nations Entity for Gender Equality and the Empowerment of Women
<b>ITGSE</b>	<i>International Technical Guidance on Sexuality Education</i>	<b>WHO</b>	World Health Organization
<b>LGBQ+</b>	lesbian, gay, bisexual, pansexual, asexual and other non-heterosexual sexual orientations		
<b>LGBTQ+</b>	lesbian, gay, bisexual, transgender, and queer/non-cisgender identities (such as intersex, gender non-binary/non-conforming and agender)		
<b>NSWP</b>	Global Network of Sex Work Projects		

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# Introduction

The first edition of the *International Technical Guidance on Sexuality Education* (ITGSE) was published in 2009 by UNESCO with UNAIDS, UNFPA, UNICEF and WHO. In the years since then, the field of comprehensive sexuality education (CSE) has experienced considerable development globally, with positive shifts in the political and cultural climate for its implementation at national, regional and global levels.

In 2016 and 2017, UNESCO led a process to update the ITGSE to reflect new evidence and good practice. The revised ITGSE was published in 2018 (UNESCO et al, 2018; all further references to the ITGSE in this publication are to this revised edition). It includes an overview of CSE; evidence on its effectiveness; and scientifically accurate key concepts, topics and learning objectives to be included in CSE curricula for four age groups: 5–8 years, 9–12 years, 12–15 years, and 15–18+ years. It also provides guidance on how to build support for, plan and deliver effective CSE programmes. The ITGSE is applicable to both in-school and out-of-school CSE programmes, but it has a stronger focus on CSE in formal education.

With the adoption of the 2030 Agenda for Sustainable Development in 2015, United Nations (UN) agencies and other development partners have committed to leaving no one behind and to reaching the furthest behind first. Among children and young people, those left furthest behind include those who are out of school and those who face discrimination and human-rights violations for various reasons. These are also the children and young people who are at greatest risk of poor sexual and reproductive health outcomes. Therefore, stakeholders requested the development of a separate guidance document focused on out-of-school CSE.

## *Purpose of this Guidance*

This *International Technical and Programmatic Guidance on Out-of-school Comprehensive Sexuality Education – Condensed Edition* is intended to be used together with the ITGSE. The ITGSE provides the basis for all CSE and supplies detailed definitions of what CSE is (ITGSE, Section 2); how it can address children's and young people's health and well-being (Section 3); the evidence base for CSE (Section 4); key concepts, topics and learning objectives (Section 5); and guidance on building support and planning for the implementation and delivery of effective CSE programmes (Section 6).

This Guidance builds upon and complements the ITGSE by providing evidence- and practice-informed guidance specifically for programmes that deliver CSE out of school, and programmes that seek to address the needs of specific groups that are unlikely to be addressed

in CSE programmes for children and young people generally. This publication offers in-depth programmatic guidance on how to develop CSE programmes that are appropriate and safe for these groups of children and young people. Thus this Guidance is intended to:

- **provide a clear definition of out-of-school CSE**
- **promote an understanding of the need for out-of-school CSE** by raising awareness of the sexuality, health and rights issues and concerns that impact children and young people, including specific groups of children and young people, and that may not be addressed in school
- **provide guidance on how to develop out-of-school CSE programmes**, including curricula and teaching and learning materials that are evidence-based, culturally responsive, age- and developmentally appropriate, and trauma-informed (see p.14), and that meet the needs of specific groups of children and young people.

This publication is a condensed edition of the full Guidance. It contains the most pertinent and practical information on planning, developing and implementing effective out-of-school CSE programmes. A complete list of references is available as a separate annex. In addition to the information contained in this condensed edition, the full Guidance includes:

- a description of the literature review that was conducted as a basis for this Guidance
- a more detailed introduction to the needs of each group of children and young people addressed in this guidance, and a description of the status of CSE for each group
- evidence on the effectiveness of out-of-school CSE, both in general and for each of the specific groups of children and young people addressed in this guidance
- detailed descriptions of a number of pedagogical concepts and approaches
- a consideration of the current status, opportunities and challenges in the implementation of out-of-school CSE.

## *Intended users of this Guidance*

This Guidance is intended to assist anyone developing or implementing CSE in out-of-school settings. This includes government departments, international and national civil-society organizations, community-based organizations, UN agencies, and young people.

## *Structure of the Guidance*

**Section 1** provides an overview of out-of-school CSE, including its definition, goals and roles, and the

# 1. Overview of Out-of-School CSE

opportunities and limitations presented by out-of-school CSE.

**Section 2** presents guidance for developing and implementing out-of-school CSE in general, as well as for engaging peer educators, involving parents or guardians, and using technology. It includes recommendations that are applicable to all the population groups discussed in Section 3.

**Section 3** provides guidance on delivering out-of-school CSE to specific groups of children and young people (recognizing that many children and young people may belong to more than one of these groups): girls and boys separately; young people with disabilities; young people in humanitarian settings; Indigenous young people; young lesbian, gay, bisexual and gender non-binary/non-conforming people; young transgender people; young intersex people; young people living with HIV; young people who use drugs; young people who sell sex; and young people who are in detention.

## *How this Guidance was developed*

In 2017, UNFPA commissioned a literature review of the effectiveness of out-of-school CSE. It was circulated for comments among a group of technical experts from around the world, working in the fields of education, health, youth development, human rights and gender equality, including researchers, ministry of education officials, NGO programme implementers, development partners and young people.

The findings of the literature review were presented and discussed at a global experts' consultation convened by UNFPA in late 2017, where participants developed a draft outline for the Guidance.

Following further feedback on the outline, the Guidance was drafted, using input from additional interviews with senior and young experts to ensure it was based on practice and responsive to the issues faced by specific groups of children and young people. Experts on the sexual and reproductive health needs of these groups were also asked to review the relevant sections. This Guidance is, therefore, based on the evidence together with the input of a wide range of experts, including the perspective of young people, and an understanding of current good practices and successful programmes. The final draft of the Guidance was shared with key experts and UN focal points for their input and feedback.

This Guidance uses the definition of CSE in the ITGSE, revised edition:

“Comprehensive sexuality education is a curriculum-based<sup>1</sup> process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with the knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider the well-being of others that are affected by their choices; and understand and ensure the protection of their rights throughout their lives.”

Characteristics of high-quality CSE are that it is:

- scientifically accurate
- incremental
- age-appropriate and developmentally appropriate
- curriculum-based
- comprehensive
- based on a human-rights approach
- based on gender equality
- culturally relevant and contextually appropriate
- transformative
- able to develop life skills needed to support healthy choices.

Detailed definitions of these characteristics are provided in the ITGSE, Section 2.1.

In-school CSE is CSE which is delivered at school to students as a part of the school curriculum (whether within or outside the regular school timetable). The ITGSE describes how CSE delivered in school provides “an important opportunity to reach large numbers of young people with sexuality education before they become sexually active, as well as offering a structured environment of learning within which to do so”.

Out-of-school CSE, on the other hand, is CSE which is delivered outside the school curriculum. Out-of-school CSE can serve a number of purposes. It can:

- provide CSE to children and young people in situations where CSE is not included in the school curriculum
- provide CSE to children and young people who are not in school

<sup>1</sup> According to the ITGSE, “curriculum-based” means that there is a written document to guide educators’ efforts to support students’ learning, which “includes key teaching objectives, the development of learning objectives, the presentation of concepts, and the delivery of clear key messages in a structured way. It can be delivered in either in-school or out-of-school settings.”

- supplement in-school CSE, particularly in contexts where it is not comprehensive or of high quality
- provide CSE that is tailored to the needs of specific groups of children and young people.

Out-of-school CSE is important because UNESCO estimates that globally 263 million children are out of school, including 63 million children of primary-school age, 61 million of lower secondary-school age, and 139 million of upper secondary-school age (UIS, 2018).

Out-of-school CSE may be delivered in face-to-face sessions by facilitators, peer educators or parents, sometimes using technology, including computers and mobile phones. This can take place in a range of settings:

- civil-society or community-based organizations
- youth centres or youth clubs
- health clinics
- summer camps
- religious institutions or faith-based organizations
- at school after hours (unless delivered by a teacher from the school to students from that school, in which case it would be considered in-school CSE)
- families (using structured parent-child programmes)
- workplaces
- institutional correctional settings such as jails, detention centres or juvenile correctional centres
- refugee camps or other shelters where people seek humanitarian support.

It is important to note that, in line with the ITGSE, out-of-school CSE programmes should be provided not only to adolescents and young people, but also in an age- and developmentally appropriate manner to younger children. This is important because children acquire information relevant to sexuality from many sources from a young age, and CSE helps ensure that their learning is accurate, safe, relevant and supportive of gender equality (Igras et al., 2014; Lundgren and Amin, 2015; Kågsten et al., 2016; Blum et al., 2017; Chandra-Mouli et al., 2017).<sup>2</sup>

Compared with CSE delivered in school, out-of-school CSE affords the opportunity to create a more informal and flexible setting than may be possible in school, with the potential for smaller learning groups, longer class times, more varied and creative delivery of the curriculum, and more interaction among learners. It can bring together children and young people with similar life experiences or living in the same context, especially those who are marginalized, provide them with CSE tailored to their specific needs, and encourage them to act as support networks for each other.

Out-of-school CSE can also include challenging topics and promote a rights-based approach rooted in gender equality and empowerment in a way that may not

always be feasible or acceptable in school settings. Facilitators can encourage learners to share questions and perspectives that they may be reluctant to voice to a teacher at their own school. Finally, out-of-school programmes may be better able to provide sexual and reproductive health commodities and link children and young people to services, mentors and other forms of support.

It is important to note that out-of-school CSE is also challenged by societal and operational barriers – often the same barriers experienced by in-school CSE. For example, it can be difficult to build community support if the curriculum content is stigmatized or considered unacceptable. But for out-of-school settings in particular, if the intended participants are members of marginalized groups, they themselves may be stigmatized by community members for attending – or even targeted by police. A further challenge is identifying, training, supporting and retaining facilitators who are motivated, skilled and have an appropriate attitude, and ensuring that they adhere to the curriculum (Vanwesenbeeck et al., 2016).

The logistics of providing adequate materials and supplies, and safe and convenient settings and times for CSE sessions, pose an additional barrier. Finally, it can be challenging to make the intended participants aware that out-of-school CSE is available, help them see it as relevant, overcome any concerns they may have about attending, and support them to overcome obstacles posed by distance or time away from other commitments. These factors can make it harder to bring children and young people together and ensure continuity with the same group of learners in order to build upon earlier learning and cover the full breadth of the curriculum (Vanwesenbeeck et al., 2016).

Notwithstanding these challenges, when out-of-school CSE programmes are implemented effectively, like in-school CSE they can also contribute to broader goals:

- **Changing social norms:** Programmes that focus solely on forming and changing the individual and interpersonal attitudes and behaviours of learners may have limited effectiveness in the long term. Programmes should contribute to a larger set of approaches that seek to reduce gender inequality and vulnerability, and change harmful social norms that contribute to stigma and discrimination (Abramsky et al., 2014; Svanemyr et al., 2015; Abramsky et al., 2016).
- **Contributing to policy change:** Equally, programmes should contribute to approaches that aim to influence governments and authorities that formulate and implement laws and policies affecting children's and young people's sexual and reproductive health and their human rights (Svanemyr et al., 2015). In

<sup>2</sup> This Guidance in most cases does not address age-specific content for out-of-school CSE programmes. References to sexual activity, sexual partners, contraception etc. should not be taken to mean that these topics are appropriate for out-of-school CSE for every age group. Readers are invited to refer to the ITGSE for specific guidance on age-appropriate curriculum content.

particular, this means advocating for children’s and young people’s access to sexual and reproductive health services. In many countries, laws and policies that restrict access to sexual and reproductive health information and services on the basis of age and marital status prevent children under the age of 18 from accessing services without the permission of parents, guardians or spouses. The concept of the evolving capacity of the child (Article 5 of the Convention on the Rights of the Child) is not generally observed, even though General Comment No. 4 of the Committee on the Rights of the Child acknowledges that States parties should ensure that children have access to appropriate sexual and reproductive health information, regardless of their marital status and whether their parents or guardians consent, and that States parties should ensure the possibility of medical treatment without parental consent. Advocacy should seek to ensure that children and young people have access to the sexual and reproductive health services and information they need to adopt healthy behaviours, provided by professionals trained in adolescent health.

While this Guidance is based on the available research and evidence, as well as the experience of developing and implementing out-of-school CSE programmes, it is limited by the lack of peer-reviewed literature on out-of-school CSE in general, as well as for the specific groups of children and young people addressed in this guidance. Many peer-reviewed articles include both in-school and out-of-school interventions and do not distinguish between them in their analyses and findings. Gaps in the evidence include:

- a limited amount of evidence from low- and middle-income countries and in humanitarian settings
- insufficient analysis or understanding of why programmes that are deemed effective work, and the key factors that make them effective
- insufficient studies of programme quality, integrity or fidelity, and of the impact of facilitators on the outcomes
- limited evidence on the impact of high-quality tech-based serious games (see Glossary) and other interactive programmes.

It is important that future research address these gaps, to allow continued building of the evidence base to support out-of-school CSE for the health and well-being of children and young people.

## 2. Developing and Implementing Out-of-School CSE

Many of the principles and approaches for developing and implementing out-of-school CSE programmes are identical or similar to those for in-school CSE, which are detailed in the ITGSE. Similarly, the core content of out-of-school CSE is the same as for in-school CSE, although some programmes may add content based on the specific needs of their participants. Sections 2.1 and 2.2 present some considerations for developing and implementing CSE that are particularly relevant to out-of-school programmes. Sections 2.3, 2.4 and 2.5 discuss how to engage peer educators, involve parents, and use technology in out-of-school CSE.

The guidance throughout Section 2 is intended to apply to CSE delivered to each of the population groups discussed in Section 3.

### 2.1 Developing programmes

#### *Creating an enabling environment*

It is important to build support for out-of-school CSE, as well as for working with specific groups of children and young people, before beginning to plan a programme. This is especially the case in communities where CSE may be considered a sensitive subject or where opposition is anticipated. Outreach to stakeholders, whether individually or in groups, should:

- explain what CSE is, providing evidence for why it is needed, and describing the programme’s goals
- understand and address stakeholders’ concerns and questions (whether positive or negative) and address any misconceptions or myths about its influence on sexual behaviour.

Relevant groups for outreach at the national (and, where relevant, local) level include:

- children and young people
- parents, guardians, other family members, and in-laws of young married women
- civil-society organizations serving and led by young people
- community leaders, e.g. civic, religious or traditional leaders
- health-care and other service providers
- the media

- the private sector
- local government representatives (e.g. at the district level)
- ministries of children, youth, health, women, gender, protection, justice, social welfare, Indigenous affairs and departments of education and non-formal education (UNFPA, 2014b).

## Planning

- **Conduct a situation analysis:** This can be done with the same categories of stakeholder as those contacted for outreach. The situation analysis can form the basis for curriculum design (Every Woman Every Child, 2017; UNFPA, 2014b). The analysis should:
  - analyse relevant laws and policies
  - gather national and local evidence about children’s and young people’s sexual and reproductive health outcomes and need for CSE. This should include HIV prevalence or incidence in specific geographic areas and among different populations to ensure adequate attention to HIV prevention, treatment and access to care.
  - identify what sexuality education already exists, including in schools, and what the key gaps are.
- **Identify all the needs of the participants to ensure that the programme meets their needs, interests and aspirations:** These may go beyond CSE, such as planning and goal-setting, education and training, and employment opportunities, in order to build their social, health and economic assets.
- **Involve local representatives of specific population groups in the development and delivery of the programme:** For example, groups representing and advocating for the rights and well-being of people with disabilities, people in humanitarian settings, etc. may be able to provide insights or resources for the CSE programme, and build support for it in the wider community.
- **Integrate or link out-of-school CSE with existing programmes:** These may include initiatives on gender equality or on violence prevention for girls and young women, programmes that engage boys and young men on gender equality or sexual and reproductive health issues, and campaigns to end child marriage, prevent transmission of HIV, promote girls’ education, promote puberty education or traditional rites of passage, or strengthen laws on gender-based violence (UNFPA, 2014b).
- **Consider supplementing individual-level education with community-level interventions:** These should seek to educate the community as a whole and address any stigma, discrimination and violence that children and young people face. This may generate more community interest and uptake and provide multiple entry points for them to access the programme.
- **Facilitate access to related services:** Contact a range of services to discuss their willingness to take referrals for children and young people, and to work with specific groups (e.g. people with disabilities, transgender people, people in humanitarian settings etc.), to the extent that the legal and social context allows. These services may include health and social services and social protection; technical and

vocational training; continuing, catch-up/remedial or non-formal education; and legal aid. Create a list of vetted services to which facilitators can confidently refer children and young people.

- **Consider the optimal timing and frequency of CSE sessions:** Out-of-school CSE can be delivered as a continuous course over a period of days, or as sessions once or twice a week over a period of time, or a combination of the two. Delivering CSE over time, e.g. weekly rather than over several consecutive days, gives participants a greater opportunity to absorb and apply what they have learned. Multiple sessions are more effective in reinforcing messages, and provide ongoing opportunities to engage with an issue, learn, and begin to change attitudes and behaviours (Nayar et al., 2014; Marcus et al., 2017). Deliver the programme in a way that does not disrupt other aspects of participants’ lives.

## Curriculum content

- **Plan the curriculum methodically:** Clearly identify goals and learning outcomes, using a logic model, and involve experts in pedagogy and curriculum development. Programme developers can be guided by the ITGSE to ensure that their curriculum covers a comprehensive range of topics. The resulting curriculum should be pilot-tested and adjusted before being rolled out (UNFPA, 2014b).
- **Develop age-appropriate content:** The ITGSE gives guidance on approaches and content for different age groups of children and young people. An incremental approach, characteristic of high-quality CSE, presents information that builds upon previous learning, taking into account the changing needs and capacities of the child and young person as they grow.
- **Be fact-based and clear:** Programmes should debunk myths and correct misinformation, not only about sexual and reproductive health, but also about groups that are subject to stigma or discrimination.
- **Take a pragmatic and non-judgemental view of sexuality:** The ITGSE emphasises a positive view of sexuality. Discussions of issues such as pornography, multiple sexual partners and sex work should be approached in a factual and pragmatic way.
- **Pay attention to what people are learning elsewhere:** Curricula should take account of formal or non-formal CSE that participants are receiving elsewhere. They should also take into account social or media influences on attitudes to masculinity and femininity, as well as access to pornography and its possible influence on attitudes and sexual behaviour, and should include strategies to actively counter or mitigate particularly harmful material in an affirming manner (Brown and L’Engle, 2009; UNICEF, 2017).
- **Be culturally relevant:** In places with multiple ethnicities and cultures, curricula must represent all cultures, not just the dominant one. Content should be relevant to a culture, but it should not overlook or dismiss rights violations resulting from harmful traditional practices or culture.
- **Tailor curricula to the unique needs of participants based on their gender:** For example, approaches to empower girls to overcome gender-based restrictions

and disadvantages might include information about their rights, and activities that promote their agency, autonomy and self-esteem, such as mentoring and sports. Boys need approaches that enable them to recognize unearned male privileges and power while supporting them to challenge stereotypical norms about masculinity and femininity (Kågesten et al., 2016). All out-of-school CSE programmes should include content to promote understanding of gender, diversity and human rights to challenge harmful gender stereotypes and systemic discrimination based on sex, sexual orientation and gender identity.

- **Address the contextual risk factors that participants face:** In addition to gender, such factors may include poverty, discrimination on the basis of race, ethnicity, religion, disability and socioeconomic marginalization.
- **Teach about advocacy:** Advocacy empowers learners as agents of their own lives and leaders in their communities. Modules on basic skills for civic engagement and advocacy can give children and young people concrete opportunities to connect what they are learning in sessions to their wider world, and to contribute to positive change in their communities. However, the decision to promote advocacy activities must always be taken with regard for the social and legal contexts, since in some places it may not be legal or safe for children and young people to engage in advocacy. In all contexts, participants must be allowed to choose freely for themselves whether to participate in advocacy.

## 2.2 Implementing programmes

### Facilitators

Facilitators can be adults, young adults, peers, health professionals or parents (Poobalan et al., 2009).

- **Adult facilitators** may be appreciated by participants for their life experience, credibility and their ability to delve deeper into topics and guide discussions on sensitive issues. They may also have higher status in the community, which can support participants' feelings of security and confidence.
- **Peers and young people** who are a few years older than participants can be effective facilitators and role models. However, their lack of teaching experience compared with older facilitators makes it especially important that they receive training, supervision and support to become effective facilitators.
- **Health professionals** providing out-of-school CSE should be trained just as other facilitators; it should not be assumed that their professional background includes knowledge of CSE, pedagogy or facilitation with children and young people.
- **Ensure that facilitators are culturally competent and can communicate clearly with participants:** If facilitators are from another social class or context, they must be able to speak in a way that participants easily understand and relate to.
- **Select facilitators for specific groups of children and young people** (e.g. people with physical disabilities, people living with HIV etc.) from the same community, where possible: If facilitators do not share this key characteristic, they must be empathetic and open to the children's and young people's experience and perspectives.
- **Assess potential facilitators for personal qualities as well as skills:** Effective facilitators should demonstrate empathy with children and young people, enthusiasm about teaching them about sexuality, and a warm and non-judgemental attitude. They should be willing to teach the full range of content of CSE, and demonstrate an aptitude for learning how to deliver CSE effectively.
- **Train facilitators in all aspects of the curriculum and its delivery:** They should be sensitized to the groups they are working with, and given ongoing supportive supervision, incorporating feedback from programme participants. For more details, see also Training and Supervision in Section 2.3, and the ITGSE, p.95.
- **Provide ongoing training to facilitators:** Capacity-building opportunities and platforms that support facilitators' professional development will help ensure that they deliver high-quality CSE programmes. High-quality job aids and implementation tools should be developed and regularly reviewed to ensure that programmes deliver updated and relevant content.

### Approaches to teaching and learning

- **Take advantage of a range of methods:** Effective teaching and learning employs diverse and interactive methods, ranging from brainstorming and discussions to reflection and analysis, from role plays to case studies, from theatre productions to group projects. Methods that encourage physical movement, like role plays or theatre, and that engage participants emotionally, such as guest speakers with powerful stories to tell, are more likely to be effective in altering perceptions and behaviour (UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO, 2018; Poobalan et al, 2009). Knowledge, attitudes, values and skills should be integrated into every topic to the extent possible, rather than only being discussed in stand-alone lessons.
- **Be inclusive:** Set expectations for respect for all, and model this. For all topics, the examples, scenarios, stories, role plays and guest speakers should include a diversity of individuals and relationships that are inclusive of all groups that are present. Teach directly about diversity and the impacts of bias, stigma and discrimination. Offer flexible lesson times that will enable as many people as possible to participate.
- **Use empowerment approaches:** Many participants described in this Guidance belong to marginalized and oppressed groups. Critical pedagogy (see Glossary) can empower children and young people from such groups by using a collaborative learning process, in which educators and learners learn from each other, developing new ways of overcoming challenges and problems together. Critical pedagogy affirms the lived experiences of the community, empowers individuals and creates community solidarity.

- **Use trauma-informed approaches:** Some children and young people may have experienced trauma, individually or as members of a group, based on discrimination, violence (including sexual violence), familial conflict, armed conflict or other humanitarian crises. Trauma may also be intergenerational. A trauma-informed approach teaches about sexuality in a way that does not re-traumatize participants by arousing feelings or memories associated with a traumatic experience (known as triggering). The essence of trauma-informed approaches is the creation of an open, safe and compassionate environment and group culture. At the beginning of sessions, always inform participants of the content that will be covered (a trigger warning) so they can choose not to participate, and post resources for easy access.<sup>3</sup>
- **Use engaging, personalized methods:** Use pictures, posters and videos, and minimize the use of printed informational materials. A discussion-based approach that allows participants to talk with their peers can help relieve the social isolation that some young members of certain population groups may experience.
- **Use methods that draw out what participants think they know:** Ask them to share what they have learned, and their sources of information, or use true/false questionnaires or games. This allows the facilitator to identify and correct specific misconceptions and misinformation that participants may have.
- **Use the participants' mother tongue whenever possible:** This helps encourage participants to understand and discuss sensitive or personal issues.
- **Consider the literacy levels of participants:** Children and young people who are out of school may have a low literacy level or be illiterate. It may be necessary to minimize activities that involve reading and writing. Instead, use experiential, participatory methods like storytelling, role plays, discussions, pictures, videos and graphics. Conversely, literacy programmes may provide a valuable entry point for integrating sexuality education content that is pitched at the learner's literacy level.
- **Provide opportunities for participants to ask questions, including ones that may be uncomfortable for them:** An anonymous question box (if participants are literate) can be a useful way to offer children and young people freedom to ask questions without fear or embarrassment.
- **Allow participants time to assimilate and practise what they are learning:** Reflection time, discussions, role plays and repetition of information within and across sessions can help children and young people understand and integrate new material and ideas with confidence.
- **Help participants apply what they learn to their lives:** Encourage children and young people to think about how to apply the information they receive to their lives, relationships and decisions. This could be done through guided imagery, journal writing,

drawing, responding to pictures, or group discussion. However, it is important for facilitators to be sensitive to experiences of trauma that can be triggered when personalizing information on sexuality and sexual health (see p.14 above for information on trauma-informed approaches).

- **Encourage participants to design their own solutions:** Asking participants to devise their own menu or range of options for reducing their risk helps them identify strategies that they can really use, rather than solutions developed by those in authority with power, which may not be feasible for them (UNESCO et al., 2018). In this way, children and young people become peer models for each other, changing their behaviour based on new understandings becomes a group norm, and learning is positively reinforced.
- **Provide CSE in a culturally safe way:** Cultural safety goes beyond the concept of cultural sensitivity. It includes analysing power imbalances, institutional discrimination, colonization and relationships with colonizers and hegemonic cultures as they apply to health education and services. Cultural safety is also critical to recognizing the intersections of physical, spiritual, mental and emotional health of children and young people.

### *Safety, security and confidentiality*

- **Create safe spaces:** Safe spaces (see Glossary for detailed definition) provide both physical and emotional safety and security and allow participants to talk about their frustrations and challenges, as well as about opportunities in daily life to do things differently.
- **Establish clear ground rules for safety and security:** This is especially important for groups of children and young people who are particularly vulnerable to harassment, discrimination and violence, including from community members or the police. Ground rules should include: respecting the confidentiality of other participants (i.e. not disclosing to non-participants the identities of participants or anything that they have said); not taking photos without permission and not posting or sharing any photos with faces in them; not mentioning names or locations, including in social media posts; only mentioning the programme to people whom they know; using messenger groups, chats or a "secret group" on Facebook if people want to stay in touch (but being aware that even supposedly secure apps may not be truly private and confidential, and may contain inaccurate information); never publishing anything about anyone without their consent.
- **Respect the physical boundaries of participants:** Participants should not be hugged, caressed, massaged, kissed or embraced by peers or facilitators.
- **When discussing sexual violence and harassment reporting, have someone on hand to whom participants can report abuse:** If it is not possible to have a contact person present, ensure that

<sup>3</sup> For more information, see *Support for Students Exposed to Trauma: The SSET Programme, Group Leader Training Manual, Lesson Plans, and Lesson Materials and Worksheets* (RAND, 2009) and *A Guide to Trauma-Informed Sex Education* (CARDEA, 2016).



participants have a concrete way of understanding whom they should contact.

- **Be clear about the importance and limits of confidentiality:** Ground rules for the programme must stress that all participants have a responsibility to maintain confidentiality, and provide clarity on what this means in practical terms. It is also essential that facilitators maintain confidentiality regarding the identity of participants and what they say. In some instances, not doing so could jeopardize their safety and security. However, facilitators should explain to participants that in some instances the facilitator may be legally required to share, with the relevant authorities, information that a participant has disclosed, in order to act in the best interests of a child below the legal age of majority.

## Monitoring

- **Integrate ongoing monitoring and evaluation:** The programme content should be regularly reviewed and revised based on the experience of delivering it and the feedback of participants. From the beginning there should be ongoing monitoring and assessment of inputs, process and outputs so that implementers can continue to shape and adapt the programme based on changes at the community or national level.
- **Monitor the fidelity with which facilitators deliver the programme:** This relates to content, methodology and programme values.
- **Identify ways to follow up with participants from the beginning:** Issues that should be considered, and which may be more challenging to track in out-of-school programmes compared with in-school programmes, include: how much of the programme has been delivered to each participant; whether the same children and young people are attending multi-session programmes; evaluating the programme with participants over the longer term.

## Key documents and curricula

- *Regional Comprehensive Sexuality Education Resource Package for Out of School Young People* (UNFPA, 2018)
- *UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender* (UNFPA, 2014)
- *The Evaluation of Comprehensive Sexuality Education Programmes: A Focus on the Gender and Empowerment Outcomes* (UNFPA, 2015)
- *IPPF Framework for Comprehensive Sexuality Education (CSE)* (IPPF, 2010)
- *Inside and Out: Comprehensive Sexuality Education (CSE) Assessment Tool* (IPPF, 2015)
- *It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education* (Population Council, 2009)
- *WHO Recommendations on Adolescent Sexual and Reproductive Health and Rights* (WHO, 2018)

- *Global Standards for Quality Health Care Services for Adolescents* (WHO, 2015)
- *HIV Prevention among Adolescent Girls and Young Women: Putting HIV Prevention among Adolescent Girls and Young Women on the Fast-Track and Engaging Men and Boys* (UNAIDS, 2016)
- *Standards for Sexuality Education in Europe: A Framework for Policy Makers, Educational and Health Authorities and Specialists* (WHO Regional Office for Europe and BZgA, 2010)

## 2.3 Engaging peer educators in out-of-school CSE

A peer educator is a person of equal standing with another – someone who belongs to the same social group based on age, grade, status or other characteristics – who is trained and supported to effect positive change among other members of that same group. For children and young people, age and sex and gender are usually key considerations for being considered a peer, but in some instances other commonalities, such as the group or groups they identify with, may be more significant. The information delivered by peers may be through one-on-one conversations, group discussions, distributing materials, counselling and games, among other activities, and they may also make referrals to services and help to lead advocacy and community mobilization (UNAIDS, 1999).

Peer education may be more effective if it is integrated in holistic interventions and if the role of peer educators is focused on sensitization and referral to experts and services (Chandra-Mouli et al., 2015a). Peer educators can work together with professional educators to deliver programmes. Peer education may be especially useful:

- when programmes led by professional educators are not available or accessible
- when adults are not fluent in the slang and colloquial language used by children and young people, especially when talking about sexuality
- where peers are more likely to be trusted than professionals or others who are not part of the learners' peer group, e.g. among children and young people who are suspicious of people who represent past or present mistreatment and discrimination; or in ethnic communities where non-members may face barriers of culture, language or experience.

Studies have found that peer education increases knowledge, and in some cases changes attitudes and intentions, although it has not been found to have a significant effect on behaviours, such as the use of condoms or other contraception (Kim et al., 2008; Medley et al., 2009; Poobalan et al., 2009; Salam et al., 2016; Tolli, 2012). (It should be noted that none of these reviews was specifically on CSE provided by same-age peer educators to their peers; one was on peer-led adolescent "sexual health education," but the actual

content was not specified.) The effects of peer education on key populations, such as people who inject drugs and sex workers, are somewhat greater, suggesting that peer education may be a more effective approach for marginalized or hidden populations (Bekker and Hosek, 2015; Krishnaratne et al, 2016; WHO, 2017b). More rigorous research on what makes some peer education programmes more effective than others is still needed, as well as research that compares the impact and effectiveness of different types of facilitators, including well-trained adult sexuality educators (Tolli, 2012; Villa-Torres and Svanemyr, 2015).

### *Programme planning and development*

- **Conduct a community needs assessment:** This is integral to programme development for all forms of out-of-school CSE, but it is frequently neglected in programmes led by peer educators. An assessment is important because scaling up peer education is not a simple process of replication: in each new setting, the social context needs to be assessed to identify factors that might help or hinder peer education (UNAIDS, 1999).
- **Clearly define the peer educator target population:** This includes considering age, gender, race or ethnicity, sexual orientation, socioeconomic factors, neighbourhoods etc. (UNAIDS, 1999).

### *Selecting peer educators*

- **Clearly articulate the selection criteria to candidates:** Peer educators should match the key characteristics of the target audience (such as age, level of education, gender identity, sexual orientation, HIV status, ethnicity, religion, academic interests, and/or extra-curricular activities). They should be charismatic and respected opinion leaders with good communication skills and credibility. They should strongly believe in the programme and want to contribute.
- **Select peer educators from a broad base of potential candidates:** Use a variety of methods to identify candidates, including social media, rather than simply expecting them to respond to a notice. The selection process should be transparent and fair, and children and young people from the target population should participate in choosing those whom they view as leaders and role models.

### *Training and supervision*

- **Provide training:** Effective training will have an extensive skills-development component, including practice facilitation in the community, and initial and ongoing evaluation of competencies. (While this is true for all facilitator training, these aspects are sometimes neglected in training peers.) Ideally, peer educators should be certified, using a process that requires them to demonstrate adequate knowledge, attitudes and skills according to pre-set competency standards known to the trainees and assessed by an

organization or persons with recognized authority and expertise.

- **Follow up initial training with mentoring support and continued “booster” training:** This will help ensure the quality of the CSE that the peer educators provide. They may require greater support than adult facilitators (including health care and counselling), particularly if they are exposed to stories of trauma. Apart from regular supervision and support groups, they should be able to access professional support when required, including on an emergency basis.
- **Provide supportive supervision:** This should include both field- and office-based supervisory sessions with programme staff who are technically competent, motivational and supportive. Supervision should identify, praise and reinforce strengths; highlight the skills or knowledge that need strengthening; offer feedback to help the peer educators become more skilful and effective; and provide ongoing encouragement and support to help keep them involved (Simba and Kakoko, 2009).
- **Provide regular opportunities to give feedback:** Peer educators should be asked for their input about the programme, its activities and their own performance. Likewise, feedback on the peer educators can be solicited from the programme participants.

### *Retention and replacement*

- **Set clear expectations that respect peer educators’ abilities and expertise:** Create a manageable scope of work and use contractual agreements. Give peer educators responsibilities and decision-making power in the planning, implementation and evaluation of the programme.
- **Provide compensation and incentives:** Paying peer educators can boost their motivation and enable young people from all socioeconomic backgrounds to participate. At a minimum they should be reimbursed for work-related expenses such as transport. However, other payments should not be so great as to create social distance between them and their peers. Other ways of incentivizing peer educators include providing personal and professional growth opportunities. Where peer educators are volunteers, they should be adequately acknowledged, and care should be taken not to exploit their free labour.
- **Offer emotional support:** This can include periodic individual and group support sessions to address issues such as stress and burnout, as well as to share successes and ideas and build group cohesion.
- **Plan for turnover or attrition:** This is common in peer education programmes and can be partially addressed by a formal structure for recruiting and training new peer educators. Exit interviews can help implementers understand whether the peer educator is leaving for personal or programmatic reasons and assess their overall experience with the programme. This information can be used to improve the programme. Involving current peer educators in the recruitment and training of new peer educators will empower them and help them develop new skills.

## Key documents and curricula

- *Peer Education Toolkit* (UNFPA, 2006)
- *Evidence-Based Guidelines for Youth Peer Education* (FHI 360, 2010)
- *Standards for HIV Peer Education Programmes* (International Federation of Red Cross and Red Crescent Societies, 2010)

## 2.4 Involving parents or guardians in out-of-school CSE

The family plays a significant role in educating children and young people about sexuality, usually in an unplanned and often unconscious way. Children learn about love, touch, relationships, communication and gender equality by observing those around them, being guided and corrected, and from the way they are treated, in addition to what they are taught explicitly (WHO, 2017c).

In places where sexuality education is not provided in schools or is not comprehensive, parents/guardians and families bear most of the responsibility for providing it to their children (Pop and Rusu, 2015), and they often prefer to be the source of information on sexuality. Despite this, parents or guardians often lack the competencies to provide evidence-based, age-appropriate sexuality education to their children. To address this, some CSE programmes seek to engage parents/guardians to deliver or support the delivery of sexuality education for their children. These approaches include sexuality education that is:

- **parent-focused:** Parents/guardians are educated or trained to provide sexuality education to their own children.
- **parent-involved:** Parents/guardians and the child participate together in sexuality education sessions or have homework assignments together.
- **parent-supported:** Parents/guardians are oriented to the sexuality education programme, so that they know what their child is learning and can reinforce or add to the messages at home.
- **parent-led:** Parents/guardians are trained to deliver programmes to other parents/guardians or to children.
- **family-based:** Parents/guardians work through a structured programme together with their child, e.g. by watching videos or listening to music together.

Some programmes may combine two or more of these approaches.

## Programme planning and development

Common components of effective interventions include:

- joint sessions for parents/guardians and their children
- promotion of parent/family involvement

- sexuality education specifically for parents/guardians and opportunities for them to practise new communication skills with their children.
- **Explain to parents/guardians the importance of their involvement in their child's CSE:** Programmes should include a focus on supporting parent-child communication before children become sexually active and should support positive beliefs in parents/guardians about communicating about sexuality with their children, e.g. that they will receive a positive reaction and that it can be effective in preventing HIV (Villarruel et al., 2008). It is important to help parents and guardians, especially of the specific groups of children and young people addressed by this Guidance, to understand their child's vulnerabilities, needs and rights related to sexuality.
- **Consult with parents/guardians:** Ask them about the level of involvement they want, their own knowledge and knowledge gaps, their concerns for their children with regard to sexuality and sexual health, and how best a programme can support them.

## Teaching and learning methods

- **Develop parents/guardians' awareness of the importance of equitable gender norms and attitudes:** Parents/guardians are key in shaping the gender norms and attitudes of young adolescents. Often, they wish their children to conform to prevailing gender norms (which are usually unequal), and they reinforce these through instruction, encouragement, rewards, admonitions and discipline (Chandra-Mouli et al., 2017). Programmes must therefore help parents/guardians to model more equal gender attitudes and norms.
- **Strengthen parent-child connectedness:** General characteristics of parent-child relationships, such as connectedness, supportiveness and conveying future expectations, may be more influential on children's sexual behaviour than specific communication about sex – and indeed have value and importance beyond the realm of sexuality education. Interventions involving parents/guardians should therefore focus on improving their monitoring and regulation of their children's behaviour; helping parents/guardians communicate their values about sexual relationships; and encouraging them to model the behaviours they want their children to follow (Wight et al., 2012; Santa Maria et al., 2015).
- **Explore technology-based programmes for parents/guardians:** Where resources allow, technology can reduce common barriers to participation in group-based, multisession programmes, such as work and family obligations, time and transportation. See Section 2.5 for more information.

## Key documents and curricula

- *Creating Connections* (Melbourne Graduate School of Education)
- *Let's Chat! Parent Child Communication on Sexual and Reproductive Health* (UNFPA, 2018)
- *Right from the Start: Guidelines for Sexuality*

*Issues, Birth to Five Years* (Sexuality Education and Information Council of the United States, 1998)

- *Parents as Advocates for Comprehensive Sex Education in Schools* (Advocates for Youth, 2002)
- *Communicating with Children: Principles and Practices to Nurture, Inspire, Excite, Educate and Heal* (UNICEF, 2011)

## 2.5 Using technology in out-of-school CSE

The potential uses of technology in contributing to the delivery of CSE are generating significant interest, especially because many children and young people are already confident and frequent users of technology (Noar, 2011; Talukdar, 2013; Holstrom, 2015; Oosterhoff et al., 2017). Where children and young people have access to the Internet and social media, these are already often a key source of information about sexuality and relationships. Technology can also be leveraged to provide structured programmes or components of programmes. Online or digital components can:

- be more accessible, since they can be accessed flexibly and conveniently, when and where the learner wants. This can be particularly useful for learners who are geographically isolated, on the move, or unwilling to meet in a group with others (or where it would be dangerous for them to do so)
- be more efficient, with the potential to reach large numbers of people at lower cost in the long run
- include content that is interactive, immersive and personalized, which may make it more transformative than other delivery methods
- be completed at the user's own pace of learning
- efficiently and safely reach specific groups of children and young people, or groups that are small in number, with information relevant specifically to them
- deliver CSE with increased fidelity, since content is fixed and not dependent on a facilitator's willingness to present it, or on their potential biases about the topic (Downs et al., 2015).

There are some caveats about using technology in CSE:

- Some approaches using technology may be less viable in resource-poor settings (or in settings where Internet access or access to electricity is limited).
- Some interventions, like serious games (see Glossary) or simulations, involve lengthy and complex development processes and require significant funding to support high-quality product development. Time and resources must be adequately planned for.
- Assessing student learning from simulations may be more complex.
- Technology may change so fast that by the time an intervention is developed and evaluated in a lengthy randomized controlled trial, the technology is already out of date.
- Although mobile Internet access is becoming more widespread and cheaper, children and young people do not have uniform access, particularly in low-income countries. There are also disparities in access due to

geography and poor infrastructure (including for those in mountainous areas, islands and some rural areas), gender, language, and levels of literacy and digital literacy (ITU, 2017; UNICEF, 2017; Broadband Commission, ITU and UNESCO, 2018; GSMA and IPSOS, 2018).

- Technology cannot replace the support and guidance of adults in a child's or young person's life. It should be seen as a useful tool, but not as a substitute for interactions with supportive adults.

## Programme planning and development

- **Assess the needs and the potential for technology to support CSE:** Identify the challenges in implementing CSE, and analyse whether and how technology could address them. Assess factors that could affect the accessibility and use of technology. This will help ensure that any technology selected is relevant, sustainable and non-duplicative (Principles for Digital Development, n.d.).
- **Build on what already exists:** To maximize the use of scarce resources, save time and avoid duplication of efforts, adapt existing products, resources and approaches, rather than creating something entirely new. Find out what is tried, tested and popular through the digital development community, conferences, blogs and programme evaluations. Build monitoring and feedback systems into the product to gather data for improvement.
- **Use available expertise:** Significant capacity is often needed to develop technology-based programmes or components, especially the more sophisticated and potentially more effective ones. Partnering with technology professionals and content experts can ensure the quality and efficiency of products.
- **Partner with children and young people:** In the development of new technological programme components, it is essential to understand the characteristics, needs, interests and challenges of children and young people, and the situations and language that they identify with. Developers should use a collaborative design process to identify solutions and build, test and redesign products until they meet user needs (Principles for Digital Development, n.d.).
- **Assess and address privacy and security:** Give careful consideration to which user and programme data are collected, and how they are acquired, used, stored and shared. Programmes must protect confidential information and the identities of individuals in data sets from unauthorized access and manipulation by third parties. Responsible practices include being transparent about how data will be collected and used, minimizing the amount of personal identifiable and sensitive information collected, creating and implementing security policies that protect data and uphold individuals' privacy and dignity, and creating a policy for managing any data after the end of a project (Principles for Digital Development, n.d.).
- **Take advantage of individualization and interactivity:** The increasing sophistication of technology has transformed the ways it can be used to make CSE more effective. Material can be individualized to

a learner's cognitive stage, level of education or sexual experience, specific knowledge gaps, gender, race, ethnicity or risk profile. Technology can also be interactive, reacting to learner choices. Examples include simulation programmes (in which the learner interacts with an environment that feels real, making decisions and practising skills), and serious games, which incorporate elements of fun and competition into simulations to increase pedagogical value. Interactive technology can provide immediate, personalized feedback and allow learners to replay situations and try different choices or solutions.

- **Ensure technology-based CSE programmes are curriculum-based:** Technological approaches to CSE without other components must have a mechanism that requires the user to proceed through and complete specific elements in a given order. If the user can choose for themselves which components of a curriculum-based programme to access and which to disregard, the learning experience and scope of content they are exposed to may not be comprehensive.
- **Plan for adequate content management and product maintenance:** The information contained in any technology programme must be kept up to date and relevant, to reduce the risk of sharing outdated or incorrect information via the Internet.

### Teaching and learning methods

- **Consider a broad range of technology-based methods for delivering components of CSE:** These could include phone calls, text messages, e-mails, mass media, websites, blogs, vlogs, videos, podcasts, apps and social networks, as well as computer- or web-based interactive education, courses, quizzes, games, simulations and serious games, virtual reality, and chatbots (computer programs that simulate conversation with human users and can answer questions).
- **Combine technology with other approaches:** Many of these methods cannot deliver CSE on their own. However, most can be used as a part of a CSE programme or as a supplement to it, in clinics, at home with parents and as a part of face-to-face programmes. For example, videos and computer-based programmes at a clinic can provide children and young people with effective education about contraception or prevention of sexually transmitted infections and HIV (Noar et al., 2009; Bailey et al., 2012; Tuong et al., 2014).

### Programme delivery

- **Seek solutions for contexts where children and young people do not have their own easy access to technology:** Interventions may be delivered in settings (e.g. clinics or schools) that can provide it; or children and young people can be equipped with mobile phones, if budgets allow (Guse et al., 2012). Another approach is to provide community-based educators with tablets or computers for their work (Bailey et al., 2010).

- **Broaden the focus of websites or apps:** Programs that address other needs and have additional desired features will help engage and retain more children and young people. It is also important to integrate across social-media platforms and across other technology.
- **Pay attention to retention of learners:** If the product is designed well (in collaboration with users), is compelling and has a step-by-step approach, retention is likely to be higher.
- **Monitor Facebook group pages, blogs and interactive fora:** When participants engage in live chat or provide information to each other, consistent monitoring by knowledgeable staff is critical to ensure the accuracy and integrity of any information presented. This is particularly important where social-media pages are used, as they may be easily subject to unwanted advertising and unsolicited posts from outside the intended audiences (UNICEF, 2011a; UNFPA et al., 2015; UNDP et al., 2016). Group administrators should also monitor for online bullying and violence.

### Key documents

- *Principles for Digital Development* (website)
- *The mHealth Planning Guide: Key Considerations for Integrating Mobile Technology into Health Programmes* (K4Health, 2014)
- *mHealth Basics: Introduction to Mobile Technology for Health* (Global Health Learning Centre, 2013)
- *The MAPS Toolkit: mHealth Assessment and Planning for Scale* (WHO, 2013)
- *mHealth Design Toolkit: Ten Principles to Launch, Develop and Scale Mobile Health Services in Emerging Markets* (GSMA, n.d.)
- *Guidelines for an Effective Design of Serious Games* (Researchgate, 2014)
- *Sex Education in the Digital Era* (Institute of Development Studies, 2014)

## 3. Delivering Out-of-School CSE to Specific Groups of Young People

All CSE programmes should be as inclusive as possible of the diversity of children and young people, educating everyone about their experiences and addressing their needs. Nonetheless, CSE for the general population of children and young people is unlikely to be able to address the specific needs of every group in depth. Furthermore, in many contexts children and young people who belong to a marginalized group will only feel safe and able to talk freely about issues related to their sexuality and health in a group of others who are like them. This section therefore provides information and guidance on providing out-of-school CSE to specific groups of children and young people. For each group, the recommendations below should be considered in addition to the recommendations in Section 2.

It is essential to recognize that many children and young people do not fall into just one of these groups. There are children and young people who are disabled and gay, children and young people who use drugs who are also in detention, young transgender people in humanitarian settings, adolescent Indigenous girls living in rural areas – in fact, children and young people with every possible combination of identities, needs and preferences. Those who are delivering CSE must always be aware of who their participants are and use an approach that acknowledges multiple identities and is responsive to their differing realities.

### 3.1 Gender-specific groups

There are benefits for children and young people of all genders to learning about sexuality together, not least because many participants will be in romantic and sexual relationships with someone of another gender at some point. However, delivering CSE to children and young people in gender-specific groups may be necessary where this is the only culturally acceptable way to provide it.

Furthermore, although some content on gender and violence will be the same for everyone, in most countries there is a gender power imbalance between men and women, and girls and boys. Gender-transformative education (see Glossary) should guide participants to undertake gender analyses for every topic so that they understand and learn to think critically about how gender issues permeate their lives. But there may be benefits in taking different emphases of approach with girls and boys – empowering girls, and enabling boys to see the benefits and value of sharing power with girls and women (Greene and Levack, 2010). Education on gender-based violence may also take different

approaches based on gender, because girls and gender non-binary or non-conforming individuals are the primary victims and survivors of violence, whereas boys' and men's gender socialization shapes them as primary perpetrators, although they too may be victims of sexual and other forms of abuse.

Programmes may be delivered entirely in gender-specific groups, or participants may be separated only for certain sessions. For adolescent girls, in particular, there are additional benefits to single-gender CSE sessions (Greene and Levack, 2010; Morrison-Beedy et al., 2013; AGSA, 2016). These have the potential to provide a learning environment with less gender stereotyping and unconscious bias, where the female voice is not marginalized, and girls take on all of the leadership roles and are instilled with self-belief.

Programme implementers should talk with any participants who are gender non-binary (see Glossary) about their preferred way to be included (Greene and Levack, 2010). One option might be to have a third group for participants who wish to participate in a mixed-gender group.

The planning, methodology and delivery of CSE for gender-specific groups will be largely the same whether it is for girls or for boys, but some features are particular to each group. This section highlights some considerations which are not always addressed, based on the literature and on the experiences of children and young people and programme implementers.

#### 3.1.1 Girls and young women

##### *Programme planning and development*

- **Identify and locate the most marginalized girls:** It is important to understand the unique risks and opportunities faced by different subgroups of girls and young women in order to tailor programmes accordingly. Targeted groups might be girls aged 10-14 or 15-19, Indigenous, married, unmarried, out-of-school, domestic workers, young mothers, etc. Programmes can define eligibility criteria and focus recruitment efforts on them. It may be effective to recruit girls who are housebound by having adult programme facilitators go from house to house to identify eligible girls and invite them to join, while explaining the programme to the adults in the household (Erulkar et al., 2013).
- **Target girls at young ages, preferably before the onset of puberty:** Equipping girls with health, social, cognitive and economic knowledge and skills early can help prevent school dropout, adolescent pregnancy, sexual violence, child marriage and transactional sex (Chae and Ngo, 2017; Austrian et al, 2018; Bandiera et al, 2020). To maintain programme effects, programmes need to be delivered to girls from early adolescence (LeCroy et al., 2017; UNESCO et al, 2018).
- **Make programmes multi-faceted to meet the needs of girls in their specific context:** Multi-component programmes that reach girls with CSE and health

services, social networks and role models, as well as micro-savings and skills-building for employment, help delay the age at marriage and can also contribute to reducing the risk of HIV infection (UNAIDS, 2016b; Engel et al, 2019).

### Teaching and learning methods

- **Address the specific interests of different subgroups:** Activities and methods should include asset-building approaches combined with CSE curricula with a focus on human rights, gender and power, and take into account the needs of younger and older girls, married and unmarried girls, and girls who are mothers. (Population Council, 2018).

### Programme delivery

- **Engage young mentors as alternative role models:** Young mentors are slightly older than girls and represent someone that they can admire, trust and ask for guidance. They can be central to the success of girl-centered programmes, and should be recruited from the community where the programme takes place (Population Council, 2016b).
- **Institutionalise programmes by establishing synergies with other sectors and platforms:** To ensure sustainability of intensive approaches reaching girls, consider working with teachers and community-based health or social workers to reinforce messaging, ensuring school continuation or re-entry, and access to health and protection services.

### Key documents and curricula

- *HIV Prevention among Adolescent Girls and Young Women: Putting HIV Prevention among Adolescent Girls and Young Women on the Fast-Track and Engaging Men and Boys* (UNAIDS, 2016)
- *Building Girls' Protective Assets: A Collection of Tools for Program Design* (Population Council, 2016)
- *Program M: Working with Young Women* (Promundo, n.d.)
- *Sakhi Saheli: Promoting Gender Equity and Empowering Young Women – A Training Manual* (Population Council, 2008)
- *Empowering Young Women to Lead Change: A Training Manual* (UNFPA and World YWCA, 2006)
- *Abriendo Oportunidades Program: Integrated Curriculum Guide* (Population Council, 2017)
- *Go Girls! Community-Based Life Skills for Girls: A Training Manual* (Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, 2011)
- *YWCA Safe Spaces for Women and Girls: A Global Model for Change* (World YWCA)

### 3.1.2 Boys and young men

#### Programme planning and development

- **Conduct group education with multicomponent interventions:** Strategies with men and boys shown

to be effective at the individual and community level in changing gender attitudes and behaviours include a combination of peer education, using male advocates, large-scale media programmes, workplace programmes and community/rights-based programming that aim to reduce gender inequality by working to change social norms (IDS, Promundo and Sonke Gender Justice, 2015).

- **Build supportive peer networks and role models for young men:** Clubs and social media groups for boys and young men which support and reinforce new ways of thinking and behaving can strengthen positive peer pressure to sustain changes in attitudes and behaviours (Namy et al., 2014; Torres et al., 2014).

### Teaching and learning methods

- **Avoid blaming participants for structural problems:** Activities should ensure that boys and young men do not feel attacked or blamed for inequality and sexual and reproductive health issues in their communities. Do not reduce the complexities of masculinity, sexuality and sexual health to problematic male attitudes and behaviours alone. Individuals should not feel responsible for overcoming complex and entrenched societal problems; instead, the CSE programme can encourage advocacy and community mobilization to target those structural factors (Dworkin et al., 2015).
- **Focus on changing attitudes and teaching skills, rather than just imparting knowledge:** Examples include contraceptive decision-making, interactions with young children and learning how to change diapers or bathe a child (Barker et al., 2007).

### Programme delivery

- **Consider using immersive environments to address the most difficult topics:** Retreats, or interactive methods such as longer in-depth discussions and time for personal reflection, are especially effective for shifting attitudes towards difficult or sensitive topics like homophobia, transphobia and violence (Namy et al., 2014).
- **Avoid replicating stereotypical language:** Language and imagery that try to engage boys and young men by appealing to stereotypical ideas of manhood, such as "Be a Man", can reinforce rather than challenge harmful types of masculinity (Gibbs et al., 2015).

### Key documents and curricula

- *Global Sexual and Reproductive Health Services Package for Men and Adolescent Boys* (IPPF and UNFPA, 2017)
- *Manhood 2.0: A Curriculum Promoting a Gender-Equitable Future of Manhood* (Promundo, 2018)
- *Program H: Working with Young Men* (Promundo, 2018)
- *Programme Ra* (Promundo, n.d.)
- *Engaging Boys and Men in Gender Transformation: The Group Education Manual* (Promundo, 2008)
- *Engaging Men and Boys in Gender Equality and Health: A Global Toolkit for Action* (UNFPA, 2010)

- *Yaari Dosti: Young Men Redefine Sexuality* (Population Council, 2006)
- *“One Man Can” Campaign Toolkit* (Sonke Gender Justice Network, 2006)

### 3.2 Young people with disabilities

There are many terms in use for types of disability. This Guidance uses the following main categories:

- **Physical disabilities** affect a person’s mobility, physical capacity, stamina or dexterity. These conditions include cystic fibrosis, spina bifida, muscular dystrophy, cerebral palsy, traumatic brain injury, spinal-cord injuries and multiple sclerosis, among others.
- **Intellectual disabilities** result in significantly reduced intellectual functions like understanding new or complex information and learning and applying new skills, which decreases a person’s ability to cope independently. These conditions can include fragile X syndrome, Down syndrome, Prader-Willi syndrome and foetal alcohol spectrum disorder, among others.
- **Sensory disabilities** affect one or more senses, including the ability to process sensory information. They include deafness and being hard of hearing, blindness and low vision, and autism spectrum disorder.
- **Psychosocial disabilities** include schizoid disorders such as schizophrenia and schizoaffective disorder, anxiety disorders such as obsessive-compulsive disorder, post-traumatic stress disorder, agoraphobia and social phobia, and mood disorders such as depression and bipolar disorder.

While people with disabilities experience the same range of sexual needs and desires as anyone else, they may have difficulties meeting those needs, depending on their disability (Sexual Health and Family Planning Australia, 2013; UNFPA and Women Enabled International, 2018). Children and young people with disabilities often have very limited opportunities for sexual exploration, for a range of reasons; for example, they may lack privacy and may have limited social circles (UNFPA and Women Enabled International, 2018). Parents/guardians often do not provide them with the chance to interact socially and romantically with others, and those around children and young people with disabilities may react negatively, express disapproval and perpetuate guilt or shame when they encounter sexual expression or normal sexual behaviours in them (Travers et al., 2014; New South Wales Department of Family and Community Services, 2016; Chappell et al., 2018). Stereotypes and negative attitudes about the sexuality of people with disabilities add to the stigma and discrimination they experience and to their difficulties in having a satisfying and pleasurable sex life (Addlakha et al., 2007).

Most children and young people with disabilities experience a reduction in life options that can negatively impact their self-esteem, and consequently their sexuality. They may have a poor sexual self-image and insufficient skills related to social interactions, dating, intimacy, sexual decision-making and safe sex; and

they may lack opportunities for appropriate sexual relationships (Eastgate, 2008; Gougeon, 2009; Swango-Wilson, 2010; Travers et al., 2014; Holland-Hall and Quint, 2017). Additionally, children and young people with disabilities (particularly girls) are significantly more likely to become victims of sexual, physical and emotional violence than those without disabilities (Jones et al., 2012; UNFPA, 2018a). Children and young people with disabilities are also less likely to report violence, seek care or access justice, in part because they are often overlooked in programmes addressing violence (Ellery et al., 2011; Jones et al., 2012).

In many countries, health services are often not physically accessible and lack support for alternative modes of communication, such as sign language and Braille (UNAIDS, 2017b). Most health programmes, including those addressing sexual and reproductive health and rights, do not consider the needs of people with disabilities. Likewise, programmes focused on disabilities may neglect to address their needs in terms of their sexuality and sexual and reproductive health and rights (WHO and UNFPA, 2009; UNFPA, 2018a).

#### 3.2.1 Young people with disabilities in general

These recommendations apply to children and young people with any kind of disability. The subsequent sections address the specific needs of those with physical, intellectual, sensory and psychosocial disabilities, with separate sections for those who are deaf, blind or autistic. The number of recommendations related to each group of children and young people varies, in part because there are differing amounts of evidence available for each disability.

#### *Programme planning and development*

- **Promote social and human-rights models of disability:** Programmes should understand that people are disabled primarily by the barriers to their full participation created by society, rather than by their impairment or difference. A social model of disability considers the barriers to inclusion for persons with disabilities, while a rights-based model centres on disability rights as human rights and promotes and protects equal social, economic and physical accessibility and inclusion.
- **Involve adults:** Because the attitudes and actions of others may hinder the development of healthy sexuality in children and young people with disabilities, especially those with intellectual disabilities, programmes should as far as possible involve all adults who play significant roles in the child’s or young person’s life, such as parents, caregivers, personal-care attendants, counsellors, teachers and other professionals they encounter (Murphy and Elias, 2006; Garbutt, 2008; Katz and Lazcano-Ponce, 2008; Rohleder and Swartz, 2009; Swango-Wilson, 2010; Chirawu et al., 2014; Travers et al., 2014; Holland-Hall and Quint, 2017; Hanass-Hancock et al., 2018b).



- **Support and encourage parents and caregivers to provide sexuality education to their children and young people with disabilities from an early age** (SIECUS, 2001; Garbutt, 2008): For children and young people with disabilities who are not in school, parents and caregivers play an even more important role in sexuality education. They can be shown how to make use of “teachable moments” – the natural opportunities for learning that arise in daily life – to promote the child’s independence, privacy and socialization and prepare them for puberty changes in advance, especially menstruation for girls and erections, ejaculation and wet dreams for boys.
- **Adapt programmes to address the needs of every participant:** It is important to do an assessment to determine whether a young person has multiple disabilities, e.g. whether a child with a physical disability also has an intellectual disability. Delivery of the curriculum should be adapted to the specific needs of participants on a case-by-case basis.
- **Be aware of how particular disabilities affect sexuality:** The onset of puberty may be earlier among children with Down syndrome and hydrocephalus, and it may begin earlier and end later among those with cerebral palsy (Murphy and Elias, 2006). Puberty may be delayed in those with prenatal or genetic developmental disabilities, and it may be late or absent in those with Prader-Willi syndrome (SIECUS, 2001). Programme content should be adjusted accordingly.
- **Vet referral services to ensure they are respectful of children and young people with disabilities:** Develop a vetted list of health and social services or professionals to which participants can be referred, including counselling and sexual abuse services (Chirawu et al., 2014; Hanass-Hancock et al., 2018a). If suitable referral services are not available, programme developers should join advocacy efforts to influence governments to provide services and to sensitize service providers.

## Teaching and learning methods

- **Ask participants their learning preferences and try to accommodate these:** Participants may prefer to learn one-on-one, in small groups or in larger groups. They should be asked how they would like facilitators to give them feedback and support their learning, e.g. by using visuals, helping them follow along page by page, going at a slower pace when reading and learning content, or watching the facilitators model a behaviour or role-play a scenario.
- **Try a range of teaching techniques to determine what works best for individual participants:** Facilitators can also empower participants by sitting or standing at their eye level (if they are not blind); explaining to them that the facilitator and the young person with a disability are equal; and by ensuring that there are clear guidelines for how a participant should ask for help, and only giving help when requested so that participants can speak and act for themselves.
- **Emphasize relevant social skills:** Skills-teaching should place a greater emphasis on practising a wide range of social skills relevant to the particular disability.

## Programme delivery

- **Where CSE is delivered to children and young people with and without disabilities together, do not segregate participants based on ability:** CSE should emphasize diversity and include an overview of the impact of disability on sexuality, without highlighting the disabilities of particular children and young people. Children and young people with disabilities should not be singled out in a setting where people have mixed abilities.
- **Provide in-depth training and ongoing support to facilitators on appropriate methods and techniques** (Sweeney, 2007): Facilitators must be able to address content specifically to each type of disability, as well as teaching general content appropriately.
- **Respect and adopt the language preferred by people with disabilities:** It is generally recommended to use “people-first” language when referring to people with disabilities (e.g. “people with cerebral palsy” and “people with learning disabilities”). However, CSE programmes should consult with children and young people in a given programme to determine how they self-identify.
- **Emphasize boundaries:** Facilitators should model and discuss with participants the importance of setting one’s own boundaries and respecting others’ (with regard to personal space, private vs. public time, thoughts and conversations, and touching) (Szydowski, 2016), as well as control over their own body and the right to refuse to be touched.
- **Provide children and young people with disabilities with opportunities to interact with peers without disabilities:** If necessary, such interactions can be arranged through adjunct activities.
- **Ensure that facilitators have access to support and referral mechanisms** to address reports of abuse, violence and sexual exploitation that may surface during or after CSE, especially when this topic is taught (Johns et al., 2014; Hanass-Hancock et al., 2018a; Hanass-Hancock et al., 2018b).

### 3.2.2 Young people with physical disabilities

#### Programme delivery

- **Consider mixed groups of participants with and without disabilities:** Joint sessions with peers without disabilities are especially appreciated by children and young people with visible disabilities who want to be educated like their peers (Esmail et al., 2010b). Additional information and supplemental material for participants with disabilities should be made accessible independently online, or through individual or small-group sessions in a safe, private environment (Esmail et al., 2010a). Note that some groups, especially those with acquired disabilities, e.g. burn survivors, might prefer CSE programmes that include only others with their disability (Parrott and Esmail, 2010).

### 3.2.3 Young people with intellectual disabilities

#### *Programme planning and development*

- **Aim to help children and young people with intellectual disabilities achieve sexual self-determination or increased empowerment** (Gougeon, 2009; Travers et al., 2014; Ginevra et al., 2016): This means fostering the sexual health and social integration of children and young people with intellectual disabilities in a comprehensive manner, within an independent-living programme where feasible (Katz and Lazcano-Ponce, 2008). Sexuality education should be started early in order to facilitate decision-making and make a positive transition into adulthood.
- **Provide opportunities to form peer relationships:** Children and young people with significant intellectual disabilities are often under constant adult supervision, which may prevent them from having meaningful exchanges with peers and building relationships. CSE should be combined with social support and social-integration programmes or activities with peers without disabilities. This allows them to practise skills learned in an authentic and inclusive environment, to gain the necessary experiential learning about sexuality that children and young people without disabilities are more likely to have routinely (Eastgate, 2008; Katz and Lazcano-Ponce, 2008; Gougeon, 2009; Swango-Wilson, 2010; Travers et al., 2014).
- **Plan group composition carefully:** Consider how to accommodate participants with various levels of cognitive abilities (Chappell et al., 2018). Groups of participants can be organized based on age or ability to help in planning activities.
- **Adapt the methodology, not the content:** In general, the content of the programme should be the same as that of their age peers (although children and young people with intellectual disabilities should be educated to understand that they are more vulnerable to several forms of abuse). However, the methodology should be appropriate to their developmental level, and some concepts should be simplified, narrowed or reframed. For example, sexually transmitted infections can be discussed in general from a prevention perspective, without going into the details of each infection.
- **Start by addressing the participant's most immediate or critical needs:** For example, for someone with Down syndrome this might include safety, social appropriateness and independence (Couwenhoven, 2007).
- **Focus on skills in making necessary distinctions:** Simple distinctions, such as boy vs. girl, men's vs. women's bathroom, can help children and young people with intellectual disabilities manage day-to-day life. It is also important to help them distinguish between people with whom it is appropriate or inappropriate to be naked, to accept help with toileting or menstrual care, to touch certain body parts or to exit school (Hanass-Hancock et al., 2018a; Johns et al., 2014; Gerhardt, n.d.).

#### *Teaching and learning methods*

- **Make demonstrations as concrete as possible:** For example, when discussing pregnancy and parenting, bring an infant to the session to explain its needs, such as feeding, diaper changes and other care (Boehning, 2006). Recommended teaching materials include three-dimensional models, anatomically correct dolls, photos, pictures, videos and diagrams.
- **Provide context for social skills and etiquette:** Situate each skill or behaviour in specific locations, e.g. how to greet someone in a shop compared with at a workplace or at home.
- **Allow time, and repeat content:** Children and young people with intellectual disabilities will need more time to assimilate learning (Murphy and Elias, 2006; Couwenhoven, 2007; Johns et al., 2014; Schaafsma et al., 2017; King County, 2018). Break activities down into small, simple steps. Content should be repeated often and taught using different environments and contexts and with unfamiliar people. Booster sessions and frequent review are required to maintain knowledge and skills (Swango-Wilson, 2010; Schaafsma et al., 2015; Visser et al., 2017). Repetition is particularly helpful for those with Down syndrome (Couwenhoven, 2007).
- **Use a lot of positive reinforcement and praise:** This will help participants to see learning about sexuality as a positive experience (Baxley and Zendell, 2011).
- **Make use of teachable moments and incidental teaching:** If someone in the room is pregnant, it is a good opportunity to teach about pregnancy (if they are comfortable with this), or a song may be playing that has content related to the lesson (Moss and Blaha, 2001).
- **When discussing sexual violence and harassment reporting, have someone on hand to whom participants can report abuse:** Some participants may be visual learners as a result of their disability, and it may also be more difficult for them to contact someone over the phone or via email. If it is not possible to have a contact person present, ensure that participants have a concrete way of understanding whom they should contact. For example, they could trace the outline of their own hand and write out the name of people they can contact and their phone number in each finger, such as a parent, the police, a counsellor or social worker. Participants should have at least three names of people to contact, so that if the first person is not available, they can reach someone else. Because the safety of children and young people is paramount, the possibility of written information being discovered by potential abusers should be discussed with participants, along with ways to keep it discreet or hidden, including how they can keep contact information safely and communicate safely and discreetly with trusted adults in their lives.

#### *Programme delivery*

- **Conduct sessions at a slower pace and include more breaks:** Do not overload participants with too much information.

- **Use the participants' mother tongue whenever possible:** This is especially important when discussing sensitive or personal issues, such as private parts of the body and different types of touching (Chappell, 2018).
- **Convey content in concrete terms:** Use clear, simple and explicit language and explanations (Katz and Lazcano-Ponce, 2008; Gougeon, 2009; Travers et al., 2014; Holland-Hall and Quint, 2017). Information should be scientific or factual but not overly technical. Avoid euphemisms like "sleeping together" or words with double meanings (Holland-Hall and Quint, 2017). Facilitators should repeat a bank of keywords or concepts throughout the programme, such as "It's private" (Johns et al., 2014).
- **In the event of inappropriate behaviour, avoid overreacting or underreacting** (Moss and Blaha, 2001): For those with very severe intellectual disabilities, the facilitator should redirect at the moment of an inappropriate behaviour, such as public masturbation or disrobing, with repetitions of redirection, rather than teaching about it only after the event, i.e. out of context.
- **Avoid intrusive physical touch:** Teach participants that their entire body is private, and their permission should be asked for before anyone touches them; about the right to autonomy of decision-making about their body, especially with regard to sterilization, contraception and pregnancy; that they have the right to say "no"; ways of greeting that do not involve hugging and kissing (so that young people with disabilities learn that greeting does not always involve an invasion of their privacy); and that only a verbal "yes" means "yes", not a nod or smile (because their disability creates a disadvantage that may lead to people not believing them if they are accused of a non-consensual sexual act).
- **cued speech** (a visual communication system in which mouth movements of speech combine with "cues" to make all the sounds of spoken language look different)
- **lip-reading approaches**
- **loop and FM systems** (wireless assistive-hearing devices which consist of a transmitter used by the speaker and a receiver used by the listener), as well as provision of captioning on audio-visual media, are important for improving accessibility of communication for people with hearing loss (WHO, 2016b).
- **Advocate for the learning of sign language by families of children and young people who are deaf, involving parents and caregivers:** This is important because it can improve communication and facilitate conversations about sexuality (Lamoureux, 2014).
- **Schedule joint sessions for parents of children and young people who are deaf and hard of hearing, where possible:** Such interventions could support parents without hearing loss to engage children and young people who are deaf in group conversations.

### *Teaching and learning methods*

- **Use visual, tactile and kinetic approaches:** These methods are better suited to the learning styles of children and young people who are deaf and hard of hearing. Methods should not rely heavily on written language.
- **Use explicit physical demonstrations:** Theatre, drama and role play will allow children and young people who are deaf or hard of hearing to observe interactions and their effects. Other useful approaches include small-group discussions, guest presenters who are Deaf, three-dimensional models for teaching anatomy and physiology, and videos in sign language (Lamoureux, 2014). Where feasible, videos should have an option to hide or unhide captioning. If the interpreter is on video, they should be shown in a larger screen, with the accompanying speaker in a smaller video.
- **Ensure written materials are adapted to the reading level of participants:** Ensure that any pamphlets or other documents include visuals like pictures and drawings. Prioritize clear visuals over words, and use simple language (Lamoureux, 2014). For participants who do not have strong language, or show slower processing speed or reduced comprehension skills, facilitators may need to use repetition, multiple exposure or long-term exposure to the same concepts.

### *Programme delivery*

- **Ensure that CSE is delivered in sign language by trained facilitators fluent in sign language, preferably ones who identify strongly with Deaf culture:** The ability of the facilitator to communicate easily and well with participants is the single most

## 3.2.4 Young people who are deaf and hard of hearing

### *Programme planning and development*

- **Be self-critical about unconscious bias:** It is important that people without hearing loss involved in designing CSE programmes be aware of common assumptions about deafness that lead to unconscious bias.
- **Promote the use of all effective and suitable means of communication:** These may include:
  - **sign language**
  - **total communication** (which incorporates all means of communication: formal signs, natural gestures, fingerspelling, body language, listening, lip-reading and speech)
  - **bilingual/bicultural** (recognizing the authenticity and importance of both hearing and Deaf cultures<sup>4</sup> and incorporating elements of both in the sessions)

<sup>4</sup>Deaf with a capital "D" is used for people who identify themselves as culturally deaf and have a strong deaf identity. "Small d" deaf people are those who do not associate as strongly with Deaf culture.

important factor in CSE for children and young people who are deaf and hard of hearing, as it is for any education for them. Relying on lip-reading is not effective for learning because the person is only able to understand a portion of what is said. For those who have residual hearing and/or assistive listening technology, such as hearing aids or cochlear implants, spoken facilitation may be workable, but only if the student is able to understand most or all of what the hearing person says.

- **Facilitators should ensure that the sign language they are using is the dialect used by the participants:** This is important because different communities have different sign language dialects (Lamoureux, 2014).
- **Address any relevant gaps in sign language:** In some sign languages, there may be no standard signs for sexual vocabulary, or participants may use slang signs. In these cases, use a participatory approach and have facilitators and participants work together to develop those signs.
- **If the facilitators do not have sign language skills, ensure that they are trained in how to work effectively with an interpreter:** The facilitator should use short sentences and allow time for sign language interpretation or lip-reading, while remaining cognizant of the fact that hearing loss does not affect participants' intellectual capacity. Any visual aids should be placed next to the signer, since that is where participants will be looking. The facilitator should avoid simultaneously speaking and pointing to visuals at the same time, as participants who are deaf and hard of hearing need time to shift their visual attention away from the sign language interpreter and attend to any visuals.
- **Ensure that interpreters can sign in the native sign language of the participants:** If the programme cannot be delivered directly in sign language and a third-party sign language interpreter must be used, check the quality of the interpreter's receptive and translation skills by asking the participants whether the interpreter is signing in a way that they understand.
- **Ensure that facilitators know how to recognize signs of abuse, including sexual abuse:** Children and young people who are deaf may not have been able to learn about sexual appropriateness by overhearing conversations or listening to radio, TV or other auditory sources, and they may have difficulty reporting abuse if their parents, caregivers or other trusted adults do not know sign language and if they struggle with oral language.

### 3.2.5 Young people who are blind

#### *Programme planning and development*

- **Consider how children and young people learn concepts about sexuality through visual observation, and how to address these with those who are blind:** Programme developers must identify these aspects of sexuality and related human behaviours and include

them in the CSE programme, such as typical body language and posture in formal and informal settings; the distance at which to stand from people based on their relationship to them; and that people can be seen through windows if curtains are not drawn.

#### *Teaching and learning methods*

- **Use appropriate materials, including in Braille, where possible:** Facilitators can also use screen-reading software, Braille keyboards and speech synthesizers, if these are available (Davies, 1996). Where Braille is not available, the methods listed below will also help to facilitate learning. For participants with low vision, use large-print materials, pictorial symbols and high-contrast materials with bright colours, and ensure that there is adequate lighting in the room.
- **Use tactile methods that allow blind students to touch materials to learn about them:** For example, to teach anatomy, sexual response and condom use, use anatomically correct models (Krupa and Esmail, 2010).
- **Describe the visual world using rich, in-depth, concrete, frank, multi-sensory descriptions:** It is important to explain concepts that have visual components, such as tall, short, muscular.
- **Explain unfamiliar concepts in detail:** Children and young people who are blind may have a different understanding of gender, body image, personal space and boundaries, anatomical differences, sexual behaviour and sexual language.

#### *Programme delivery*

- **Use facilitators who are blind and ones who are sighted:** While facilitators who are blind are recommended, it is also important for participants who are blind to learn from a facilitator with sight, because it can be helpful for them to hear a sighted person's perspective and visual descriptions.
- **Provide close attention to participants:** CSE using tactile methods should be provided either one-to-one, or in small groups without children and young people without disabilities, for whom tactile methods are not appropriate. Allow participants who are blind to direct questions to their peers with low vision (Hanass-Hancock et al., 2018a).
- **Respect the physical boundaries of participants:** Facilitators may use physical demonstrations, but they should always ask participants for their permission before touching their bodies, as this informs them of what will happen and ensures that they know they can control who touches their body.

### 3.2.6 Young people with autism spectrum disorder

In general, for lower-functioning children and young people with autism spectrum disorder, and especially those who also have cognitive disabilities, the recommendations in Section 3.2.3 on intellectual disabilities should be applied. Those who are very high-functioning are likely to be in mainstream schools, receiving CSE there, if offered.

#### Teaching and learning methods

- Use methods developed specifically to teach and reinforce learning in children and young people with autism. These include:
  - **applied behaviour analysis**<sup>5</sup>
  - **social stories technique**<sup>6</sup>
  - **discrete trial training**<sup>7</sup>
  - **visual supports**: a series of pictures or visual representations of what the participant is supposed to do, to remind them and enable them to do it independently
  - **shaping**: the facilitator provides reinforcement only for close approximations of the desired behaviour they are teaching
  - **cognitive rehearsal**: the facilitator and participant work together to find and practise ways in which a certain problem can be handled
  - **personalized stories**: stories that explain social situations and that are customized to the participant, e.g. containing pictures of them or their family members and friends, to teach the participant what to expect and how to act in those situations
  - **modelling behaviours**: either in person or using a video (Gerhardt, 2013).
- **Make lessons situation-specific**: Contextualization is more important than repetition for those with autism spectrum disorder. Probe participants' understanding, rather than using a lot of repetition. Provide multiple examples to aid generalization of concepts (Gerhardt, n.d.).
- **Adopt group work or individual activities, depending on the participants**: For those with mild or moderate autism spectrum disorder, small group work is recommended, but for those with severe autism spectrum disorder, only short periods of group work are recommended, with mostly individual activities.
- **Keep visual resources simple**: Pictures should not be complex or cluttered, because participants may focus on the details rather than the overall meaning of the picture (Gerhardt, n.d.). The focus of pictures should

be easily identifiable by the participant. Participants may need help interpreting facial expressions or body language in images (Johns et al., 2014).

- **Focus on concepts rather than details**: Participants with autism spectrum disorder may focus on the detail of each concept rather than the concept itself. It may be difficult for them to grasp social concepts, so facilitators should teach everything in simple steps, and focus on their understanding of concepts (Johns et al., 2014).

### 3.2.7 Young people with psychosocial disabilities

#### Teaching and learning methods

- **Take into account potential difficulties with cognitive processing or speaking**: People with psychosocial disabilities may have such challenges due to their symptoms or their medications, which may lead to difficulty concentrating, drowsiness, agitation or heaviness in their tongue. In these cases, it may be necessary to use methods similar to those recommended for people with intellectual disabilities.
- **Use concrete examples, multisensory activities and role playing, where appropriate**: These should be designed appropriately to the young person's condition. Role playing is helpful for children and young people with psychosocial disabilities to practise playing the other side's part, since they may find it more difficult to put themselves in another's place.

#### Key documents and curricula

- *Sexuality across the Lifespan for Children and Adolescents with Developmental Disabilities* (Florida Developmental Disabilities Council, 2011)
- *Sexual Health Education for Students with Differing Abilities* (Alberta Health Services, 2017)
- *FLASH Curriculum in Sexual Health Education: Lesson Plans for Special Education* (Public Health Seattle & King County, 2005-13)
- *Personal Safety Planning Awareness Choice Empowerment (SPACE): A Violence Prevention Programme for Women* (The Arc Maryland)
- *Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights* (UNFPA, 2018)
- *Addressing Issues of Sexuality with Participants Who Are Visually Impaired* (Perkins School for the Blind, 2014, video)
- *The Center on Secondary Education for Students with Autism Spectrum Disorders (CSESA)* (website)
- *Sexuality and Disability* (website)

<sup>5</sup> For a description, see <https://www.autismspeaks.org/applied-behavior-analysis-aba-0>

<sup>6</sup> For a description, see <http://best-practice.middletonautism.com/approaches-of-intervention/social-stories/>

<sup>7</sup> For a description, see <https://www.autismspeaks.org/expert-opinion/what-discrete-trial-training>

- *Supporting People with Learning Disabilities to Develop Sexual and Romantic Relationships* (National Development Team for Inclusion, 2016)
- *Young Persons with Disabilities: Global Study on Ending Gender-Based Violence and Realizing Sexual and Reproductive Health and Rights* (UNFPA, 2018)
- *Talking about Sex and Relationships: The Views of Young People with Learning Disabilities* (CHANGE, 2009)
- *It's about Ability: An Explanation of the Convention on the Rights of Persons with Disabilities* (UNICEF, 2008)
- *Healthy Relationships, Sexuality and Disability: Resource Guide 2014 Edition* (Massachusetts Department of Public Health, 2014)
- *Impact: Feature Issue on Sexuality and People with Intellectual, Developmental and Other Disabilities* (Institute on Community Integration & Research and Training Center on Community Living, University of Minnesota, 2010)
- *Human Sexuality Education for Students with Special Needs* (MarshMedia, 2007)
- *Teaching Sexuality to Developmentally Disabled Youth: What Do I Say? How Do I Say It?* (Resource Center for Adolescent Pregnancy Prevention, website)
- *Resource List for Teaching People with Sensory Disabilities Social Skills and Sexuality Education* (Perkins School for the Blind, 2014)
- *PleasureABLE: Sexual Device Manual for Persons with Disabilities* (Disabilities Health Research Network, 2009)
- *Disability and HIV* (UNAIDS, 2017)

### 3.3 Young people in humanitarian settings

Humanitarian crises happen as the result of an event or series of events that threatens the well-being, safety or health of a large group of people. Crises may be sudden-onset, cyclical or slowly evolving. They may have natural causes or be man-made, and can be a consequence of natural disasters, armed conflicts, persecution and/or genocide, epidemics, climate change, famine, or poverty and inequality resulting in mass economic migration.

Young people in humanitarian settings may be:

- **internally displaced**, meaning they are still living in their own country, but have had to flee from their home
- **refugees**, meaning they have had to leave their own country, usually for a neighbouring one
- **separated**, meaning they are children (i.e. under the age of 18) who have become separated from both parents or their legal or customary primary caregiver, but not necessarily from other relatives. They may be accompanied by other adult family members
- **unaccompanied**, meaning they are children who have been separated from both parents and other relatives

and are not being cared for by an adult who, by law or custom, is responsible for doing so

- **stateless**, meaning they are not considered as nationals by any country under the operation of its laws.

It is estimated that over half of all refugees are under the age of 18 (UNHCR, n.d.). In 2017, there were more than 173,000 unaccompanied and separated children (UNHCR, 2017). The majority of refugees and internally displaced people live in urban environments, not in camps (USA for UNHCR, 2018). Their situations are often fluid: they may be on the move, itinerant or migratory, or get trapped in a specific place. Sometimes they live in the wilderness or on the streets, or they may be housed in shelters or held in detention centres.

During humanitarian crises, the everyday structures and institutions that support the healthy growth and development of children and young people are disrupted: their schooling is typically interrupted or discontinued, community and social networks break down, and families are often separated. Children and young people in such situations experience adolescence with less access to the education, information, facilities and services they need, and with fewer safeguards. Those separated from their families or who are heads of household may be compelled to drop out of school, engage in exploitative labour, sell sex, or marry in order to meet their needs for food, shelter or protection (Kerner et al., 2012). Moreover, in the chaotic periods during and following humanitarian crises, they face a heightened risk of sexual violence, abuse and exploitation (Kerner et al., 2012).

All of the above leave children and young people in humanitarian settings particularly vulnerable to early pregnancy, unsafe abortion, sexually transmitted infections and HIV, social stigmatization, and psychological distress and trauma (Kerner et al., 2012). Children and young people who become refugees or asylum seekers must often contend with cultural differences related to sexuality and relationships in the country that receives them, especially if they move from a conservative to a liberal country where they may not understand the sexual values, language, customs or related laws.

### *Programme planning and development*

- **Include CSE programming in emergency preparedness:** It is essential to ensure that sexual and reproductive health interventions for children and young people, including CSE, are not overlooked at the onset of emergencies. Needs vary according to the phases of humanitarian response, which include disaster preparedness and risk reduction; minimum response; comprehensive response; and recovery (Women's Refugee Commission et al., 2012).
- **Be aware that children and young people in humanitarian settings are often highly mobile:** Because some children and young people may not remain in one place for very long, sessions provided in

a concentrated period, rather than spaced out, may be a more effective way to reach them, and each lesson should contain discrete information (i.e. complete information on a subject, rather than carrying over to the next lesson). Develop sessions that can be delivered in a range of time frames, from single, quick sessions with the most pertinent information to comprehensive sessions and programmes.

- **Pay particular attention to the vulnerabilities of lesbian, gay, bisexual and transgender children and young people in humanitarian settings:** These young people can be especially vulnerable in humanitarian settings because of lack of access to programs that are safe, inclusive, and responsive to their needs (WRC, 2016).
- **Integrate or link CSE with other services, including for sexual and reproductive health, wherever possible:** A holistic, multisectoral, integrated approach can include non-CSE-related life skills, literacy and numeracy, vocational training and livelihood skills (Women’s Refugee Commission et al., 2012). It may be helpful to integrate CSE into other existing or planned activities, including gender-based-violence prevention work.
- **Integrate programmes with the local and/or host community where possible:** In places where refugees or internally displaced persons are integrated with the local population, programmes should also be integrated and include both groups.
- **Do not assume that sexuality cannot be addressed in a conservative culture:** This is particularly important for programme developers from outside the culture. Investigate what is available in the context already, or in similar places. In refugee settings, populations often come into contact with a more diverse range of people, which can expose them to new experiences, ideas, messages and programming.

### Teaching and learning methods

- **Take the participants’ level of literacy into consideration and ensure that everyone can participate equally:** Children and young people in emergencies, especially in protracted crises, are likely to have missed a lot of school and often have large gaps in their education. Therefore, they are more likely to be illiterate or have low literacy skills. Use methods that are appropriate to the literacy level of the learner.
- **Provide girls with opportunities to socialize, network and organize among themselves:** Support girls’ protection and empowerment by giving them the time and space to build friendships and find mutual support among peers and adults in their communities (Women’s Refugee Commission et al., 2013; IRC, 2017).

### Programme delivery

- **Consider multiple channels to deliver CSE, depending on the humanitarian setting:** These include through direct government services, nongovernmental organizations or the UN; at fixed locations, such as youth centres, women’s and girls’ safe spaces, youth clinics or other health services; in mobile classrooms, where the facilitators are brought to the population; or remotely, using technology. There may also be existing girls’, boys’ or youth groups that programmes can link with to provide CSE.
- **Use creative and flexible outreach strategies to reach children and young people, particularly girls, in insecure environments and hard-to-reach areas:** Increase participation by offering flexible access to the programme, and run programmes at times when participants are most available. Programmes should budget for transportation (Women’s Refugee Commission et al., 2012).

### Key documents and curricula

- *Girl Shine Program Model and Resource Package* (IRC, 2018)
- *My Safety, My Well-being: Equipping Adolescent Girls with Key Knowledge and Skills to Help Them to Mitigate, Prevent and Respond to Gender-Based Violence (GBV)* (IRC, 2016)
- *Boys on the Move Life Skills Programme for Unaccompanied Male Adolescents: Facilitator Handbook, Participant Book, Brochure* (UNFPA, 2019)
- *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (UNFPA, 2009)
- *Healthy Relationships, Healthy Communities Curriculum: Incorporating Mental Health, Social Norms and Advocacy Approaches to Reduce Intimate Partner Abuse* (ABAAD Resource Center for Gender Equality, 2018)
- *Safe You and Safe Me* (Save the Children, 2006)
- *Equal You and Equal Me* (Save the Children, 2010)
- *Adolescent Sexual and Reproductive Health in Humanitarian Settings eLearning* (online course) (Inter-Agency Working Group on Reproductive Health in Crises, 2016)

### 3.4 Young Indigenous people

Indigenous people are the descendants of those who resided in a geographical region before different cultures or ethnicities settled in their territory and before the creation of modern states and borders.<sup>8</sup> Estimates point to over 370 million Indigenous people spread across the globe in over 90 countries (World Bank, 2019). Indigenous people have preserved distinct social, cultural, economic and political institutions that are reminiscent of pre-colonial societies, and they have unique practices, beliefs and languages that distinguish them from the dominant or mainstream cultures in their geographical area (WHO, 2007b). In general, they espouse a strong sense of community and embrace connections to the lands on which they live (UNDP, 2019).

The concept of self-determination for Indigenous children and young people relates not only to their own bodies and sexual and reproductive rights, but also to their strong connections with their culture, community, history and land. The sexuality of Indigenous children and young people must be understood in the context of their cultural practices, beliefs and cosmology. For instance, traditional rites of passage and coming of age ceremonies are practices that empower young Indigenous people to better understand and fulfil their sexuality in a culturally appropriate manner.

As populations with colonial origins have become dominant over time, Indigenous peoples have been relegated to a minority status in many places. Forced assimilation to colonial or dominant religious and cultural practices, involuntary relocation (e.g. due to environmental degradation) and coercive integration into formal educational systems have all contributed to intergenerational community trauma (Reading and Wein, 2013). Today Indigenous peoples represent one of the world's most disenfranchised population groups (WHO, 2007b). They face inequalities in almost all indices of human development, including health, education and income, and Indigenous children and young people lack access to high-quality health care, education, justice and political participation (WHO, 2007b; Inter-Agency Support Group on Indigenous Peoples' Issues, 2014).

Many Indigenous children and young people face challenges growing up at the intersection of two different cultures, which can impact their psychological and sexual well-being and development. In addition to the barriers to sexual and reproductive health affecting most disadvantaged groups, such as lack of sexuality education, lack of access to care, poor basic health conditions, and unequal gender norms, many Indigenous children and young people face specific challenges, including a lack of culturally appropriate care that takes into account traditional preventive care, healing practices and medicines (Inter-Agency Support Group on Indigenous Peoples' Issues, 2014). Inappropriate and unresponsive services, compounded by experiences

of discrimination and distrust in the system, lead many Indigenous children and young people to delay seeking care, in particular for sexual health, or not to seek care at all (State of Queensland, 2013). In some regions Indigenous children and young people are disproportionately affected by behavioural risk factors for HIV transmission, including substance use, teenage pregnancy, risky sexual behaviour, and poor sexual health (PAHO, 2011).

In the absence of extensive published literature on the CSE needs of Indigenous children and young people, most of the recommendations in this section are based on interviews with representative community members.

#### *Programme planning and development*

- **Make interventions specific to the Indigenous context and culture:** Programmes must respond to and engage with past and present Indigenous notions of health and illness, traditional medicinal knowledge and practices (United Nations, 2014). When working with Indigenous communities, programme developers must take into consideration the effects of colonization (historical or current), oppression, racism and deculturation that have traumatized entire communities. They must also consider the current socioeconomic context, which may include high rates of crime, suicide and community and family violence among small, tightly knit communities in remote areas that lack access to services (PAHO, 2011).
- **Use an intercultural approach:** Programmes should develop conceptual frameworks that respect and draw upon Indigenous culture and that link participants' biological, spiritual and emotional lives to address all components of sexual and reproductive health (Reading and Wein, 2013; United Nations, 2014).
- **Make programmes holistic and address whole communities:** CSE should also target the parents and grandparents of Indigenous children and young people, to build their capacities for intergenerational dialogue on these issues (United Nations, 2014).
- **Recognize that the sexual and reproductive health and rights of Indigenous peoples are interlinked with the respect, protection and fulfilment of the other rights in the United Nations Declaration on the Rights of Indigenous Peoples:** This includes their right to self-determination, which has been identified as the most important indicator of health for Indigenous peoples, and their right to free, prior and informed consent (United Nations, 2007). For this reason, active participation and engagement of Indigenous children and young people in the planning and development of programmes is particularly important.
- **Allocate adequate resources of time and budget:** Substantial human and financial resources are required to build relationships and work collaboratively with disparate and often remote Indigenous communities.

<sup>8</sup> In line with human-rights principles, "Indigenous" should be applied to those individuals who self-identify as Indigenous on a personal level and who are also accepted as a member by an Indigenous community.



- **Identify all the needs of the participants and keep the programme broad to meet their needs, interests and aspirations:** These may go beyond CSE, such as planning and goal-setting, education and training, and employment opportunities, in order to build their social, health and economic assets. CSE should be linked with other programmes and schemes that Indigenous children and young people can benefit from, such as returning to school, getting a diploma, and vocational training.
- **Plan for linguistic needs:** In some countries, languages may vary from community to community. Additionally, Indigenous languages may not have terms for all the concepts in sexuality or may use very different terms, so considerable preparatory work may be required with people in the communities who understand all the languages used in the programme.
- **Build rapport:** While not all Indigenous people live in rural environments, programme developers entering a remote or secluded community from outside must take time to build a rapport with the community, and be open-minded about its traditional practices by practising intercultural approaches. For each topic, they should find out and understand what the community's beliefs, knowledge and practices are, working with local community members.

## Teaching and learning methods

- **Respect and use cultural methods of teaching and learning, and provide CSE in a culturally safe way:** Cultural safety goes beyond the concept of cultural sensitivity. It includes analysing power imbalances, institutional discrimination, colonization and relationships with colonizers and hegemonic cultures as they apply to health education and services. Cultural safety is also critical to recognizing the intersections of physical, spiritual, mental and emotional health of Indigenous children and young people. Examples of culturally safe sexuality education include rites of passage that incorporate peer education and mentorship related to sexuality and relationships, and cultural teachings that are empowering, knowledge-based and free of stigma or judgement (United Nations, 2014).
- **Use trauma-informed approaches:** Most Indigenous peoples have experienced cultural humiliation, and intergenerational community trauma and violence – whether collective, institutionalized, interpersonal or self-inflicted – is a serious problem for Indigenous children and young people (UNDESA, 2015; UNDESA, 2017b; PAHO, 2018). For information on trauma-informed approaches, see p.14.
- **Integrate Indigenous arts and art practices:** In many Indigenous cultures, arts may serve as an expression of community identity and a channel of information, and it may therefore be appropriate to include artistic activities in CSE.
- **Recognize the deep connection and relationship of Indigenous peoples to the land:** Where relevant, CSE could be delivered outdoors. Approaches should support Indigenous perspectives, values and practices, acknowledging that learning occurs through the

observation and cultivation of the relationship between people and the land. In CSE, this could include Indigenous ways of treating and caring for themselves, and Indigenous medicines.

- **Take a harm reduction approach to teaching about harmful practices or any self-harming behaviour:** It is important to work with Indigenous children and young people starting from where they are and help them to move along a spectrum of strategies to be safer. Harm reduction interventions must be designed to reflect specific individual and community needs.
- **Take the participants' literacy levels into consideration:** Where literacy is low, keep printed material to a minimum. Be aware that some languages do not have a script.

## Programme delivery

- **Choose facilitators who are culturally competent:** Indigenous children and young people and their communities strongly prefer Indigenous- and peer-led approaches, because these recognize the importance of self-determination and are culturally safe (UNFPA, 2015a). Other approaches may favour and impose external worldviews and attitudes about sexuality and create power imbalances in favour of non-Indigenous people. Young Indigenous people may also look to elders for information in cultures where they play a particularly important role. Programmes should also provide community members with training to be able to deliver the education themselves, or train young people to give workshops and ask them to help.

## Guidelines and other key documents

- *Routine Practices at Indigenous Healing Ceremonies* (Spruce Woods Sundance Family, 2017)
- *Promoting Equality, Recognizing Diversity: Case Stories in Intercultural Sexual and Reproductive Health among Indigenous Peoples in Latin America* (UNFPA, 2010)
- *Safe and Caring Schools for Two Spirit Youth: A Guide for Teachers and Students* (Society for Safe and Caring Schools & Communities, 2011)
- *A Community of Practice Approach for Aboriginal Girls' Sexual Health Education* (Journal of the Canadian Academy of Child and Adolescent Psychiatry, 2006)
- *HIV/STD Prevention Guidelines for Native American Communities: American Indians, Alaska Natives, & Native Hawaiians* (National Native American AIDS Prevention Center, 2004)
- *Indigenizing Harm Reduction* (Native Youth Sexual Health Network, n.d.)
- *United Nations Declaration on the Rights of Indigenous Peoples* (United Nations, 2007)

### 3.5 Young lesbian, gay and bisexual people, and other young men who have sex with men

This section of the Guidance addresses lesbian, gay and bisexual children and young people separately from transgender children and young people, and intersex children and young people. This recognizes that sexual orientation, gender identity and physical sex traits are distinct parts of a person's identity, and that each group has its specific needs.

For this reason, this Guidance uses the acronym "LGBQ+", rather than the more common "LGBTQ+". LGBQ+ refers only to (non-heterosexual) sexual orientations. Although "Q" (for "queer") is part of the acronym, this Guidance avoids referring to it outside the acronym, because it is not in common use in all countries.

In some contexts, intersex people may not want to be considered part of what is known as the LGBTQ+ community, because it may put them in danger. Children and young people with intersex traits may identify with a range of sexual orientations and gender identities, and the relevant recommendations from the sections below will apply to them. However, these communities are often grouped together in the LGBTQ+ terminology and join forces to advocate for their rights because they all may experience similar social oppression, stigma and discrimination. While they have distinct needs related to sexuality education, these groups may benefit from coming together to learn and to understand each other better.

Sexual orientation refers to the gender of the people to whom a person is romantically and/or sexually attracted:

- **Heterosexual (straight)** people are primarily or entirely attracted to people whose sex or gender is different from theirs.
- **Homosexual** people (**gay men and lesbians**) are primarily or entirely attracted to people whose sex or gender is the same as theirs.
- **Bisexual** people are attracted to people of both the same and different sex or gender.
- **Pansexual** people are attracted to all gender identities (male, female, transgender, etc.).
- **Asexual** people do not feel sexual attraction to others, or have a low or no interest in or desire for sexual activity.

Sexual orientation should be seen as a continuum. A person's orientation is not necessarily fixed and may change over the course of a lifetime. Some people do not choose to label themselves in any particular category. Sexual orientation (a person's feelings of attraction) is distinct from sexual identity (how a person defines themselves) and from sexual behaviour (what they actually do). For example, "men who have sex with men" is used to describe all males who have sex with other males, regardless of whether they also have sex with women or whether they identify as gay, bisexual or heterosexual. Social environments and situations (e.g. hostels, detention centres, correctional homes) can also influence the choice of sexual partner. For these and other reasons (including fear of self-disclosing one's orientation), the number of children and young people who are LGBQ+ globally is not known. Estimates vary significantly and are widely debated.

Although some LGBQ+ children are aware of their sexual orientation from a young age, many discover it when romantic and sexual attractions start during adolescence. In cultures that stigmatize or condemn same-sex attractions, this realization often results in a mixture of confusion, shame, fear, self-stigma or self-hatred, while at the same time they may have no one to turn to for support or help.

LGBQ+ people are commonly denied their rights to dignity, equality and non-discrimination, security, health, education and employment, as well as their rights to freedom from torture, cruel, inhuman or degrading treatment and arbitrary detention. Laws that discriminate against LGBQ+ people are common, including prohibitions of same-sex relations, same-sex marriage and the right to form LGBQ+ organizations. Those living in societies, cultures, traditions and religions that do not accept them face stigma and discrimination, serious violations of their rights, and often severe violence, including rape and murder.

Given the hostility they face, LGBQ+ people, including children and young people, may feel that they have to hide their identity. In some cultures, young LGBQ+ people may form relationships with people of the opposite sex in order to avoid stigma and discrimination or violence from their families or communities, or for childbearing; or they may be forced to marry by their families. If their sexual orientation or behaviour becomes known, they may face rejection from their families, communities and religions. They may be kicked out of home by their families, skip school or drop out entirely because of bullying and harassment from both teachers and students, or lose their employment.

The criminalization of same-sex behaviour, and discrimination by health-service providers, are barriers to young LGBTQ+ people's access to health services and lead to poorer health outcomes. These include a much higher rate of HIV among young men who have sex with men than in the general population (UNFPA et al., 2015; Keifer and Arshad, 2016). Studies have found that in some countries young LBQ+ females are more likely to experience pregnancy than heterosexual females in the same age range (Lindley and Walsemann, 2015; Hodson et al., 2017). The isolation, rejection and ongoing violence that LGBTQ+ children and young people experience mean that attempted suicide and suicide rates are much higher among them than among young people generally (Haas et al., 2011).

### *Programme planning and development*

- **Consult local or national groups for LGBTQ+ people, where these exist, on the programme and the most appropriate ways of reaching and engaging LGBTQ+ children and young people:** There are strong activists in every country.<sup>9</sup> For CSE specifically focused on gay and other young men who have sex with men, their networks for HIV prevention work can be contacted.
- **Provide CSE to people of all LGBTQ+ identities:** It should not be limited to those considered most at risk of HIV, i.e. gay and bisexual men and other men who have sex with men.
- **Take into account the legal status of LGBTQ+ people:** Many countries criminalize same-sex sexual behaviours. Decisions on curriculum content, the age of participants, and where and how CSE will be delivered must take the local situation into account, and programmes must be planned with the safety of participants and programme staff foremost in mind.
- **Understand and adapt to the culture, values and belief systems of the group the programme will address:** Identify or adapt solutions or strategies to fit the sexual cultures of LGBTQ+ young people, rather than trying to impose public-health measures on them that are at odds with that sexual culture.
- **Plan programming to reflect that LGBTQ+ children and young people and young men who have sex with men are not homogeneous groups:** Different identities among LGBTQ+ young people will have both common and divergent needs and interests and may want to have their own programmes. In particular, because of the effects of gender inequality, programme developers should discuss with young lesbian and bisexual women whether they want a programme that addresses their needs separately from gay men. If separate programmes are developed, they should be open to those who are gender non-binary or gender non-conforming and allow them to decide where they fit best. In addition, there are many different identities in each of these groups, which may vary by country. Programmes should recognize the different identities in the group

and address their diverse needs.

- **Consider joint sessions to strengthen empowerment:** Because LGBTQ+ children and young people face similar experiences in terms of exclusion, stigma and discrimination, conducting some sessions jointly may foster a sense of community and promote joint advocacy efforts.
- **Vet referral services to ensure they are respectful of LGBTQ+ children and young people:** Where possible, it is particularly important to link CSE to LGBTQ+-friendly health and mental-health programmes or professionals. If suitable referral services are not available, programme developers should join advocacy efforts to influence governments to provide services and to sensitize service providers.
- **Consider online outreach:** Where those the programme is trying to reach have access to the Internet, online outreach may be an important complement to using peers for outreach, since peers can only reach a limited number of people, usually those in their own network (UNFPA et al., 2015). This may be especially true for young men who have sex with men, because in an increasing number of countries they may go online to find partners (UNFPA et al., 2015).

### *Teaching and learning methods*

- **Use a trauma-informed approach:** If the experience of being LGBTQ+ results in trauma in the place where the programme is being implemented, trauma-informed CSE should be used (see p.14).
- **Allow participants plenty of opportunities to talk:** A discussion-based approach that allows participants to talk about the experience of being LGBTQ+ with others who also are LGBTQ+ will help relieve the isolation that many experience.
- **Be fact-based and clear:** Programmes should debunk myths and correct misinformation about being LGBTQ+.

### *Programme delivery*

- **Recruit facilitators with diverse identities:** If the main facilitator is not a member of the LGBTQ+ community, it is strongly recommended to have a co-facilitator who is. Bring in a wide range of LGBTQ+ people from the different identities represented among participants to tell their stories.
- **If using technology, take precautions to protect participants:** The platforms should be discreet enough that participants are not identifiable. Programme developers should discuss with participants the safest ways to contact them, how often to send notifications, and what privacy options participants can use. Make sure participants can opt in or out of identification and notifications. They may not wish to register using their personal email addresses.

<sup>9</sup> For a list of organizations see Wikipedia ([https://en.wikipedia.org/wiki/List\\_of\\_LGBT\\_rights\\_organizations](https://en.wikipedia.org/wiki/List_of_LGBT_rights_organizations)) or contact OutRight International (<https://www.outrightinternational.org/about-us>) or the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) (<https://ilga.org/about-us/contacts>).

- **Exercise caution about using printed materials about LGBTQ+ issues:** It may be dangerous for participants to keep the materials outside the learning environment.

### Key documents and curricula

- *Being Out, Staying Safe: An STD Prevention Curriculum for Lesbian, Gay, Bisexual and Queer Teens* (New Jersey Department of Health and Senior Services, n.d.)
- *Implementing Comprehensive HIV and STI Programmes with Men Who Have Sex with Men: Practical Guidance for Collaborative Interventions* (UNPFA, 2015)
- *HIV and Young Men who Have Sex with Men: Technical Brief* (WHO, 2015)
- *Faith Leaders and the LGBT Community Toolkit: Promoting Safe and Welcoming Faith Organizations for All God's Children* (Sonke Gender Justice Network, 2017)
- *Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth in the Global South: The Facts* (Advocates for Youth, 2016)
- *Out With it: HIV and Other Sexual Health Considerations for Young Men Who Have Sex with Men* (MPact Global Action for Gay Men's Health and Rights, 2018)
- *Compassion-centred Islam network* (website)

### 3.6 Young transgender people

A person's understanding of their gender identity emerges over time, based on the interrelationship of the following three elements:

- **their physical body**, which is the basis upon which societies almost always assign sex and hence gender at birth, and which subsequently determines how others interact with them
- **their gender identity**, which is their deeply felt internal sense of themselves as male, female, a blend of both, or neither, and which may or may not correspond with the sex assigned at birth
- **their gender expression**, which is how they present their gender to others through external characteristics such as appearance, clothes, grooming, style, mannerisms, speech, interests and behaviour, which may be socially defined as masculine, feminine or neutral.

How a person experiences their assigned gender is related to the extent to which these three aspects coincide.

- A **transgender** person's gender identity and/or expression is different from their legal or assigned sex; therefore, they often question their legal or gender identity and may want to change it.
- A **cisgender** person's gender identity is the same as their assigned sex, so they are less likely to question it.
- A person with a **non-binary** gender identity does not identify as strictly male or female.

- **Agender** people do not identify with any gender.
- People who are **gender non-conforming** do not follow societal conventions regarding gender identity and expression for their assigned sex.

In this Guidance, "transgender" is used (unless otherwise indicated) as an umbrella term for all non-cisgender people, i.e. anyone whose gender identity and/or gender expression differs from that typically associated with the sex assigned to them at birth.

Accurate data are not available on the size of transgender populations globally, nor therefore on the number of young transgender people.

Transgender children and young people often have limited access to the information, messages and role models that they need to understand and affirm their identity. Their parents, teachers, health-care providers and wider communities often lack information and understanding about what they are experiencing, especially during puberty. While transgender adolescents who receive gender-affirming health care can have positive outcomes (De Vries et al. 2014), those who live in low- and middle-income countries are unlikely to have access to health-care providers with relevant expertise or to biomedical interventions such as hormone blockers and hormone therapy. The legal age of consent for health care often poses another obstacle for those who are not open with their parents about being transgender but who seek access to hormones or surgical procedures, as they cannot access health care without their parents' involvement until legally allowed, which is at 18 years of age in many countries.

Feeling unsafe as well as unwelcome, young transgender people often drop out of school, leave home or are thrown out of home. They may subsequently face workplace discrimination that can lead to underemployment or unemployment and poverty. Many may be exposed to violence or become involved in situations and behaviours that could endanger their health, such as selling sex in situations where they cannot negotiate condom use (Operario et al., 2008); using hormones obtained informally (e.g. bought on the streets), which may involve sharing unclean needles; and/or abusing substances (UNDP et al, 2016).

Regardless of their socioeconomic status, young transgender people may experience serious consequences to their health and well-being from the combination of systemic social and economic marginalization, stigma and discrimination, violence and lack of access to gender-affirming health care (United Nations, 2011; Reisner et al., 2016). As a result, they have much higher rates of depression, anxiety, trauma, attempted suicide, intentional self-harm, HIV and sexually transmitted

infections than the general population, as well as of substance use and abuse (Clements-Nolle et al., 2001; Health Policy Project et al., 2015; Reisner et al., 2016; Winter et al., 2016).

In the absence of extensive published literature on the CSE needs of transgender children and young people, most of the recommendations in this section are based on interviews with transgender organizations and representative community members.

### *Programme planning and development*

- **Consult local or national groups for transgender people, including children and young people:** Where such groups exist, they will be able to provide valuable input on the programme and the most appropriate ways of reaching young people who are transgender.<sup>10</sup>
- **Balance the need for publicity with ensuring the safety and confidentiality of programme participants and staff:** Rather than announcing the location and time of sessions in public, it may be safer to provide contact information for the programme, which makes it possible to screen potential participants.
- **Understand the various gender identities and needs of young transgender people in the programme:** For example, transmen and transwomen often have very different needs and circumstances, so some programmes or parts of programmes may need to address them separately.
- **Make sure that the language used about the programme is clear:** Language should be inclusive of all participants, so programmers should find out about and use the terminology that the community or individuals in it use.
- **Vet referral services to ensure they are respectful of young transgender people:** Where possible, it is particularly important to link CSE to all services they need, including trans-friendly health and mental-health programmes or professionals. If suitable referral services are not available, programme developers should join advocacy efforts to influence governments to provide services and to sensitize service providers.
- **Devise a secure system to maintain strict confidentiality:** Protect any personal information about participants from access by individuals, groups or organizations hostile to transgender people.
- **If an existing curriculum is being adapted, be thorough and deliberate in the process:** This requires more than just adapting the language to make it more inclusive or changing all the names to be gender-neutral.
- **Use technology and social media, where possible and appropriate:** Some young transgender people already use technology and websites like YouTube for information on being transgender, transitioning

etc. Technology and social media may therefore be an effective way to reach them or to teach them in the programme itself.

- **If possible, sensitize parents about gender identity:** Discuss the support their children need to foster a positive sense of themselves, develop their self-esteem, and prevent a variety of health consequences.

### *Teaching and learning methods*

- **Use a trauma-informed approach:** Many young transgender people are traumatized by their repeated experiences of stigma and discrimination or by violence they have experienced. (For further information, see p.14.)
- **When talking about sexual and reproductive anatomy, label diagrams inclusively:** Diagrams should not be labelled as male and female, and body parts should not be assigned to one gender. Teaching anatomy can be approached by asking participants what words they use for each part, allowing for a range of labels.
- **Allow participants plenty of opportunities to talk:** A discussion-based approach that allows participants to talk about the experience of being transgender with others who also are transgender will help relieve the isolation that many experience.
- **Provide mental-health support:** If possible, programmes should have trans-friendly mental-health counsellors available during and after sessions and provide referrals to trans-friendly mental-health professionals. If this is not possible, facilitators should be alert to these issues and provide support to anyone who appears to have been triggered.
- **Debunk myths and misinformation:** Directly address misconceptions and false information about transgender people that are prevalent in the community where the programme is delivered.

### *Programme delivery*

- **Use transgender community members as facilitators whenever possible:** Ideally, at least one facilitator should identify with the group being educated. If the main facilitator is not a transgender person, or if the programme is addressing more than one identity, it is beneficial to have a transgender co-facilitator. When it is possible to have two facilitators it may be advantageous for them to have different gender identities. It can be powerful to have someone who is cisgender and an ally as a facilitator, as long as they are trained and well versed in the issues.
- **Use the gender pronouns preferred by the participants:** Facilitators should introduce themselves with their names and preferred gender pronouns (e.g. she/her/hers, he/him/his, they/them/theirs) and then ask participants to introduce themselves. In this way,

<sup>10</sup> For a list of organizations, see : [https://en.wikipedia.org/wiki/List\\_of\\_transgender-rights\\_organizations](https://en.wikipedia.org/wiki/List_of_transgender-rights_organizations), [https://en.wikipedia.org/wiki/List\\_of\\_LGBT\\_rights\\_organizations](https://en.wikipedia.org/wiki/List_of_LGBT_rights_organizations).

participants are given the opportunity to share their pronouns if they wish. No one should be required to share pronouns or any other personal information.

- **Consider supplementing and/or linking individual-level education with community-level interventions:** These should seek to educate the community as a whole and address stigma, discrimination and violence against transgender people. This may generate more community interest and uptake and provide multiple entry points for young transgender people to access the programme.

### Key documents and curricula

- *Implementing Comprehensive HIV and STI Programmes with Transgender People: Practical Guidance for Collaborative Interventions* (UNDP, 2016)
- *HIV and Young Transgender People: Technical Brief* (WHO, 2015)
- *Blueprint for the Provision of Comprehensive Care for Trans People and Trans Communities in Asia and the Pacific* (Futures Group, Health Policy Project, 2015)
- *Blueprint for the Provision of Comprehensive Care for Trans People and Their Communities in the Caribbean and Other Anglophone Countries* (John Snow, Inc, 2014)
- *A Guide to Supporting Trans Children and Young People* (Action for Children, 2016)
- *Transgender Health* (Lancet, 2016)
- *The Yogyakarta Principles: Principles on the Application of Human Rights Law in Relation to Sexual Orientation and Gender Identity* (2007) and *the Yogyakarta Principles plus 10* (2017)
- *APTIN Fact Sheets: Being Trans in Asia and the Pacific* (Asia Pacific Trans Network, 2016)
- *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, 7th Version* (World Professional Association for Transgender Health, 2012)
- *Dr. Rad's Queer Health Show – Self Exams and Checkups* (RAD Remedy, n.d.)
- *Mermaids* (website)
- *Gender Spectrum* (website)
- *Transcending Anatomy #1: A Guide to Bodies and Sexuality for Partners of Trans People* (Anarchist Zine Library, n.d.)

### 3.7 Young intersex people

Intersex people have biological sex characteristics that do not fit typical binary notions of male or female bodies. They may have differences in their chromosomal patterns, in their gonads (usually testes or ovaries) and/or sexual and reproductive organs due to variations in the process of prenatal sexual development. These are not pathologies or diseases, but simply natural variations in the human body. Being intersex relates to biological sex characteristics only – it is distinct from the person's gender identity and sexual orientation. Hence, an intersex person may identify their gender as female, male, both or neither, and their sexual orientation may be straight, gay, lesbian, bisexual, asexual or another.

Intersex variations are more common than may be assumed, since intersex people and their unique needs and characteristics are often not recognized by others. A survey of the medical literature from 1955 to 2000 of studies on the frequency of intersex traits concluded that they occur in about 1.7% of live births (Blackless et al., 2000), although this depends on which traits are included as intersex.

Although most variations cause no life-threatening health problems, there is a long history of medical interventions on intersex infants and children. These often irreversible procedures can be driven by a disputed perception that early "correction" will let the individual develop as a "normal" male or female. Parents are frequently advised not to tell their children that they are intersex and to conceal the truth about why they need surgery. This can lead intersex children to feel confused, isolated and ashamed. When such procedures are medically unnecessary, they violate the human-rights of intersex infants and children, as they cannot provide their free and informed consent. Human rights bodies have indicated that full, free, and informed consent by the individual concerned is a prerequisite for invasive, irreversible procedures for intersex persons (WHO, 2014), and if possible, any such procedures should be postponed until a child is sufficiently mature enough to participate in the decision-making process and make an informed decision (European Commission Directorate-General for Justice, 2012; Deutscher Ethikrat, 2012).

Children may learn they are intersex during early adolescence, if they do not experience puberty (e.g. beginning menstruation, growing body hair, developing breasts or muscle mass) as expected. When a child or young person finds out that they are intersex, they may think about or question their gender in new ways. Those who realize that they were assigned the wrong sex on paper and through surgery may choose to transition to another gender.

An intersex person's biology and any previous procedures they have undergone may or may not affect their sex life.

Some physical differences may make vaginal intercourse difficult without dilation, or impossible. Genital surgeries may affect their sexual response or cause sex to trigger memories of the trauma of the surgeries. Discovering that they are not the only person with their intersex trait, and finding support groups and connecting with other intersex persons, is important and therapeutic.

In the absence of extensive published literature on the CSE needs of intersex children and young people, the recommendations in this section are based on interviews with intersex organizations and representative community members.

## *Programme planning and development*

- **Involve the local or regional intersex community in the development and delivery of the programme:** If that is not feasible, it is essential that one or more intersex people are included in the development process.<sup>11</sup>
- **Identify appropriate terminology:** Some languages lack words for intersex or may use the same term for intersex and transgender. Programme developers should identify the preferred terms together with the community.
- **Understand how intersex variations are viewed in the cultures where the programme will be used:** In some cultures, intersex people are seen as being special or as a third sex, or there may be deities that are intersex, whereas in other cultures they may be stigmatized. In some countries the intersex community may choose to distinguish itself from LGBTQ+ communities and individuals, for a variety of reasons.
- **Recognize and be prepared to deal with the diversity of young people with intersex traits:** Apart from the variety of intersex traits, intersex children and young people will have differing levels of knowledge about their variation, and differing levels of acceptance and understanding of it. They will also have a wide range of experiences related to being intersex, e.g. some may have had multiple surgeries, while others may not have had any.
- **Consider how to identify and reach potential participants:** When doing outreach or press, always provide contact information, such as an email, telephone number or website, so that people can contact the programme. There may also be support groups for specific variations, and young intersex people may know others like them. Use a variety of terms, not just “intersex” but also “people with variations of sex characteristics” and “differences of sexual development” and other terms that people may identify with locally, so that everyone can identify the programme.
- **Balance the need for publicity with ensuring the safety and confidentiality of programme**

**participants and staff:** The risk of bullying and other types of violence against intersex young people is contextual. Rather than announcing the location and time of sessions in publicity campaigns, it may be safer to provide contact information for the programme, which makes it possible to screen potential participants.

- **Devise a secure system to maintain strict confidentiality:** Protect any personal information about participants from access by individuals, groups or organizations hostile to intersex people.
- **Vet referral services to ensure they are respectful of young intersex people:** Where possible, it is particularly important to link CSE to the services they need, including intersex-friendly health and mental-health programmes or professionals. If suitable referral services are not available, programme developers should join advocacy efforts to influence governments to provide services and to sensitize service providers.
- **Establish an intersex-only space, where possible:** This is important for creating community, safety and healing. It also affords privacy, which is important because many intersex people do not want others to find out that they are intersex.
- **Consider including sessions for parents:** Among various reasons, it may be helpful for parents to address their feelings about the decisions they made about medical interventions on their child. If participants wish, there can also be joint sessions with parents.

## *Teaching and learning methods*

- **Use a trauma-informed approach:** The surgeries and stigma that many young intersex people experience during their childhood and adolescence may be traumatic for them, and programmes should take this into account. (For further information see p.14.)
- **When talking about sexual and reproductive anatomy, label diagrams inclusively:** Diagrams should not be labelled as male and female, and body parts should not be assigned to one sex. Teaching anatomy can also be approached by asking participants what words they use for each part, allowing for a range of labels.
- **Use methods that draw out what the children and young people think they know about intersex variations:** Ask them to share what they have learned, and their sources of information, or use true/false questionnaires or games. This allows the facilitator to identify and correct specific misconceptions and misinformation that participants may have.

<sup>11</sup> For a list of organizations see the websites of InterACT (<https://interactadvocates.org/resources/intersex-organizations/>) and Intersex Day (<https://intersexday.org/en/links/>).

## Programme delivery

- **Use the gender pronouns preferred by the participants:** Facilitators should introduce themselves with their names and preferred gender pronouns (e.g. she/her/hers, he/him/his, they/them/theirs) and then ask participants to introduce themselves. In this way, participants are given the opportunity to share their pronouns if they wish. No one should be required to share pronouns or any other personal information.
- **Consider using technology to reach a larger number of people, where possible:** Since intersex people form a relatively small proportion of the population and are often not willing to self-identify in groups, they may appreciate additional CSE components offered through videos online or a video conference or webinar with an interactive portion. However, it is important for there to be an in-person component to the programme.

## Key documents and curricula

- *InterACT (Advocates for Intersex Youth)* (website)
- *Fact Sheet: Intersex* (United Nations Office of the High Commissioner for Human Rights)
- *Intersex on vk.com* (videos)
- *dsdteens* (website)
- *How Sex Development Works* (website)
- *Supporting Your Intersex Child: A Parents' Toolkit* (Organisation Intersex International Europe, 2018)
- *Full Frontal Activism: Intersex and Awesome* (website)
- *Brief Guidelines for Intersex Allies* (Organisation Intersex International United States, 2012)
- *Defining: Intersex* (website)
- *9 Ways Intersex Youth Want You to Support Them* (Everyday Feminism, 2015)
- *What Does It Mean to Be Young and Intersex Today?* (Dazed Digital, 2016)

## 3.8 Young people living with HIV

In 2019 there were an estimated 1.7 million adolescents living with HIV globally, and approximately 170,000 new HIV infections among adolescents aged 10–19 years (UNAIDS, 2020). There are around 3.4 million young people aged 15–24 living with HIV, and approximately 28% of all new infections occur among young people (UNAIDS, 2020).

Most children and young people living with HIV acquire it in one of two ways: perinatally around the time of birth and through breastfeeding (around 70% of cases), or later, as a result of unprotected sex, sexual abuse, rape, sharing drug-injecting equipment, transfusions with unscreened blood, or needle sticks. While children and young people who acquire HIV in either way share some similarities, many of their experiences and needs are distinct (UNAIDS, 2016a; STOPAIDS et al., 2016).

Beyond perinatal infection, children and young people who acquire HIV, particularly in adolescence, most often do so through unprotected sex. Reasons for this include poor knowledge of HIV prevention, low risk perception for HIV, low condom use, multiple sex partners, being raped or coerced into unprotected sex, and early sexual debut (WHO et al., 2015a; WHO et al., 2015b). A frequent cause of HIV transmission is sharing drug-injecting equipment, for reasons that often include a lack of sterile equipment for safe injection (WHO et al., 2015b).

Children and young people who belong to key populations – gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and other incarcerated people – are particularly vulnerable to acquiring HIV, because of the widespread discrimination, stigma and violence they face, in addition to specific vulnerabilities associated with being young (WHO et al., 2015a; WHO et al., 2015b). Furthermore, if they are minors, they may not be covered by government programmes for key populations, where these exist.

Increasing access to antiretroviral therapy has enabled many of those who were born with HIV to live into adolescence and young adulthood. However, they may experience developmental delays associated with immune impairment, and health challenges such as co-infection with tuberculosis (Bridges, 2011; Eison and Kim, 2018). They also have higher rates of mental-health problems, most often anxiety and depression, in part because of stigma and discrimination against people with HIV, and this can impact their quality of life and adherence to medication (UNICEF, 2016). During adolescence they often have complex emotions about their developing sexuality and their reproductive options, and struggle with making decisions about sexual activity and disclosure of their HIV status (APN+, 2013).

Children and young people living with HIV, like all children and young people, need education and services (Bridges, 2011). However, laws on age of consent for health care often prevent children from accessing sexual and reproductive health care, including HIV prevention, testing and treatment services, without parental consent. Stigma and discrimination can deter children and young people from getting counselling on safer sex and getting tested for HIV, especially those from key populations, for whom late diagnosis is often a problem. Children and young people may skip taking HIV medication for several reasons, and especially to avoid disclosing their status to observers. Common issues with treatment include the lack of adolescent-specific services, and health-care providers' lack of understanding of the needs of adolescents living with HIV. Other factors are distance and cost of transport to the clinic, fear of others noticing their clinic visits, long waiting times, and judgemental attitudes towards those who are sexually active. Many clinics also lack protocols and trained staff for transitioning adolescents from paediatric to adult HIV services (IPPF European Network et al, 2017).



## Programme planning and development

- **Tailor CSE to the needs of children and young people living with HIV, and do not focus only on sexual risk reduction:** In some places it may be advisable to develop a specialized CSE package for children and young people living with HIV who are from key populations, because their issues are different and more complex, and the legal and policy environment for them differs as well.
- **Engage key people in participants' social networks and support systems:** Programmes should help parents and guardians, religious leaders and health-care providers to understand the realities, rights and sexual and reproductive health needs of children and young people living with HIV, and develop their skills to talk with children and young people about living with HIV, disclosure of HIV status, sexuality and sexual and reproductive health (Stangl et al., 2015), and to help them to live positive lives.
- **Use recruitment strategies to ensure that programmes reach those with the greatest need:** When participants are recruited through clinics and health centres, only children and young people living with HIV who are already linked to care will be reached. Such participants are already likely to have better sexual and reproductive health outcomes than those who are not accessing care, such as marginalized groups and those who have not begun treatment or have dropped out (Pretorius et al., 2015). Where possible, consider reaching young people online also, where they may meet in closed communities on social media.
- **Supplement CSE with additional sources of information on sexuality and sexual and reproductive health that can be accessed discreetly through the Internet or in clinic waiting areas:** These might include multimedia materials, videos, brochures, young people-oriented smartphone apps and helplines (Stangl et al., 2015).
- **Consider whether or not to include the term "people living with HIV" in the name of the programme:** In some contexts, children and young people living with HIV do not want others to know their status.
- **Devise a secure system to maintain strict confidentiality:** Protect any personal information about participants from access by individuals, groups or organizations hostile to people living with HIV.
- **Do not assume that children and young people living with HIV are already well informed:** They may not have much knowledge and understanding about HIV and how it progresses, what it means to be HIV positive, what antiretroviral medicines are, their side-effects or what adherence is. This can happen if doctors communicate only with their parents or guardians, who may not educate their children, or because communication is not tailored to the young person themselves.

## Teaching and learning methods

- **Provide mentoring for younger adolescents living with HIV:** They may benefit from support from older young people living with HIV who have navigated sexuality and relationships.
- **Offer role models:** Invite young people living with HIV who have come to terms with their status, or who are in healthy romantic partnerships (including with partners who are HIV negative), to talk with participants (APN+, 2013).
- **Strengthen decision-making and communication skills:** Provide demonstrations and plenty of opportunities for participants to practise explaining HIV, disclosing their status, answering questions and handling reactions.

## Programme delivery

- **Create a safe space for all participants:** Because of the diverse identities of children and young people living with HIV, simply gathering them in one place does not necessarily make it safe for everyone. In some contexts, it may be necessary to deliver CSE for key populations living with HIV – such as gay men or transgender women – separately from those from the general population, who may discriminate against them or may disclose their status.
- **Be sensitive to participants' daily routines:** Deliver the programme in a way that does not interfere with participants' schedules for taking their medications and eating meals, and does not disrupt other aspects of their social lives, including participation in HIV peer support groups.

## Key documents and curricula

- *iCAN Package: A Comprehensive Life Skills Package Focusing on HIV, Sexuality, and Sexual & Reproductive Health for Young People Living with HIV (YPLHIV) and Their Circles of Care – Facilitator's Manual and Workbook* (SAfAIDS and UNFPA, 2016)
- *Adolescents Living with HIV: Developing and Strengthening Care and Support Services* (UNICEF, 2016)
- *Children's HIV Association (CHIVA)* (website)
- *Lost in Transitions: Current Issues Faced by Adolescents Living with HIV in Asia Pacific* (APN+, 2013)
- *Advancing the Sexual and Reproductive Health and Human Rights of People Living With HIV: A Guidance Package* (GNP+, 2009)
- *HIV and Adolescents: Guidance for HIV Testing and Counselling and Care for Adolescents Living with HIV* (WHO, 2013)
- *Positive Learning: Meeting the Needs of Young People Living with HIV (YPLHIV) in the Education Sector* (UNESCO, 2012)
- *Positive Health, Dignity and Prevention: Operational Guidelines* (GNP+ and UNAIDS, 2013)

### 3.9 Young people who use drugs

While tobacco and alcohol are the most widely used drugs and have serious consequences for children's and young people's sexual behaviour and health, illegal drugs – especially those that are injected – have received the most attention since the onset of the HIV epidemic. Global data on psychoactive substance use among young people are limited, but there are indications that drug use is much higher among young people than older people. Most research suggests that 12–17 years of age is a critical risk period for the initiation of substance use, which may peak around the ages of 18–25 (UNODC, 2018).

Drug use among children and young people differs from country to country and depends on social and economic circumstances: the majority of children and young people who use illegal drugs are relatively poor in the societies in which they live, which can increase the likelihood of sharing needles or trading or selling sex for drugs (UNODC et al., 2017). Although in many regions of the world drug use is part of an intergenerational cycle, with multiple members of a household affected, it can also be part of adolescent experimentation, risk-taking and reward-seeking, especially among peers. Socializing with young people who use drugs also normalizes and reinforces the behaviour. Some children and young people start using drugs to escape from psychological or physiological pain resulting from adversity or negative experiences, such as neglect; physical, sexual or emotional abuse; difficulties with their families; or feelings of alienation, anger or emptiness. Many face multiple vulnerabilities (WHO et al., 2015b).

Because their cognitive functions are still developing, children and young people are more susceptible to drug abuse and addiction than adults, although they may outgrow it. Drug use can reduce young people's inhibitions and compromise judgement, including about sexual behaviour, such as whether to use a condom (WHO et al., 2015b). Together with sharing needles and drug equipment – and crucially in the context of a general lack of harm reduction interventions for children and young people – these factors can result in a greatly increased risk of HIV, sexually transmitted infections and hepatitis among children and young people who use drugs, especially among those who inject drugs (WHO et al., 2015b).

Young people who use drugs face multiple barriers in accessing the services they need such as information, sterile injecting equipment and drug dependence treatment. These barriers include the lack of harm reduction services focused on and accessible to young people; lack of confidentiality due to age of consent restrictions that require those under 18 to get parental consent for harm reduction and health services; judgemental attitudes of providers; and denial of health care due to drug use. There is a lack of evidence-based harm reduction, opioid substitution therapy or treatment for withdrawal symptoms (GPN+ and INPUD, 2010; Larney et al., 2017). Consequently, young people who inject drugs are more likely to lack knowledge of risks to

their health, safer injecting practices and HIV prevention than older people, and are more likely to delay testing for HIV, which also increases the chance of onward HIV transmission (AVERT, 2019).

Criminalization and punitive policies and practices increase stigma, prejudice and discrimination, drive people who use drugs underground, reinforce their marginalization and further decrease access to services (WHO, 2016a). For example, the legal repercussions of drug use and the threat of losing custody of their children discourage young pregnant women or mothers who use drugs from accessing services (GPN+ and INPUD, 2010). Other socioeconomic consequences include dysfunctional social relationships and an increased likelihood of unemployment and detention.

#### *Programme planning and development*

- **Ensure that interventions targeting children and young people who use drugs are contextually appropriate:** Those developing CSE need to understand how drug use occurs, its diversity, how it is changing, how harm reduction and treatment are done, related laws and the approach of law enforcement to drug use and people who use drugs. They should also understand the diverse needs and motivations of children and young people who use drugs, the social and economic dynamics of their lives and the factors that make children and young people vulnerable to using drugs.
- **Plan comprehensive integrated care and services, including education:** Programmes should strive to link or integrate CSE with other programmes for young people who use drugs (GPN+ and INPUD, 2010; UNODC et al., 2017). The more pressing needs of children and young people, for example shelter and food, should be addressed first, otherwise they may not participate. As far as possible, programmes should offer holistic support, or link participants to other sources of such support. This includes (IPPF European Network et al., 2017):
  - harm reduction (including commodities such as sterile injecting equipment) and evidence-informed drug treatment
  - HIV prevention, testing, treatment and care
  - sexual and reproductive health services, including for family planning, sexually transmitted infections and hepatitis
  - mental-health services, peer-led social support
  - services for survivors of violence
  - support and counselling for parenting and child custody issues, childcare services, social welfare services and legal services, especially for children and young people who use drugs who are street-based or homeless.
- **If CSE is not integrated with comprehensive services, have a list of vetted young-people-friendly local resources for children and young people who use drugs:** If suitable referral services are not available, programme developers should join advocacy efforts

to influence governments to understand and respond to drug use as a public-health issue rather than a criminal one, to provide suitable treatments, replace moralizing attitudes with a pragmatic approach to drugs use, and base clinical and therapeutic practice on scientific evidence (GPN+ and INPUD, 2010).

- **Devise a secure system to maintain strict confidentiality:** Protect any personal information about participants from access by individuals, groups or organizations hostile to people who use drugs.
- **Provide the means for participants to change their behaviour:** Programs should provide not only accurate information and education about health care and an emphasis on risk reduction, but also the means for participants to change their behaviour, such as access to male and female condoms (Des Jarlais and Semaan, 2008).
- **Engage parents of young people who use drugs, but only with the young person's consent:** Parental engagement can help to ensure adequate support for the young person, but it is essential to obtain the young person's consent before involving the parents.

### Teaching and learning methods

- **Provide participants with opportunities to set their own goals for behaviour change:** Help them commit to realistic goals for healthier behaviours (Edlin et al., 2005; Des Jarlais and Semaan, 2008).
- **Acknowledge that abstinence from drug use is not always a realistic goal:** Programmes should acknowledge that sustaining abstinence from drug use is difficult and that success may require several attempts. Emphasize the importance of risk reduction for participants who continue to use drugs.

### Programme delivery

- **Develop relationships with participants that demonstrate respect:** Avoid common pitfalls, such as moralizing or feeling angry or frustrated with participants (Des Jarlais and Semaan, 2008). Research has shown that when people who use drugs are treated with dignity and respect, they are willing to learn and respond with concern for their own health and the health of others (Des Jarlais and Semaan, 2008).
- **Try to identify and engage children and young people as soon as possible after they start using drugs:** Ideally this should be before they start injecting, at which point the risk of infection with HIV through sharing of nonsterile injecting equipment increases greatly.
- **Minimize barriers to participation:** For example, deliver the programme in places where children and young people who use drugs already go, where they feel safe, or where they can receive multiple services.

### Key documents and curricula

- *Implementing Comprehensive HIV and HCV Programmes with People who Inject Drugs: Practical Guidance for Collaborative Interventions* (UNODC, 2017)

- *HIV and Young People Who Inject Drugs: Technical Brief* (WHO, 2015)
- *Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users Living with HIV: A Policy Briefing* (GNP+ and INPUD, 2010)

### 3.10 Young people who sell sex

Sex workers are female, male and transgender adults and young people, over 18 years of age, who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, which takes many forms. It varies between and within countries and communities and in the degree to which it is "formal" or organized (Harcourt and Donovan, 2005). Those under the age of 18 who sell sex are considered sexually exploited children rather than sex workers, in line with the UN Convention on the Rights of the Child (even if they have made the decision to sell sex themselves, and/or do not see themselves as sexually exploited).

There are no accurate global estimates of the number of young people engaged in selling sex, in part because in most countries, one or more acts concerning the selling, offering, obtaining, procuring or providing of sex are criminalized (WHO et al., 2015a).

Young people who sell sex may have multiple vulnerabilities, such as being homeless, migrant or itinerant, alienated from their family of origin, struggling with mental illness, and being the victim of violence by family members, intimate partners, clients, third parties or the police (WHO et al., 2015a). Their well-being may also be threatened by problematic drug use, sexually transmitted infections, unintended pregnancies and unsafe abortions, and discrimination (WHO et al., 2015a). While those under the age of 18 who sell sex are technically considered victims of exploitation or trafficking, in practice they are often arrested or otherwise targeted by police. They, along with those who are 18 years or older, are frequently viewed as criminals and face arrest, imprisonment and other punitive practices as well as bribery and harassment by police, even in some places where sex work is legal.

Sexually exploited children aged 10–17 may have less control than sex workers over the number of clients they have, for reasons including economic need, abuse of power and authority by adults, threats of violence, or lack of negotiating experience (WHO et al., 2015a). Furthermore, in many countries, those under the age of 18 cannot access sexual and reproductive health care or HIV services without the consent of their parents or guardians, unless they are emancipated minors (UNAIDS, 2012). They are made more vulnerable to violence, including sexual violence, when they cannot access support or assistance because they fear arrest, detention or discrimination.

Some young people are victims of trafficking for the purposes of sexual exploitation. Children and young

people who are sexually trafficked may experience extreme human-rights violations, including starvation, confinement, beatings, rape, gang rape, forced drug use, and threats of violence to themselves and their families and of exposure of their activities to family and friends. Health consequences may include physical injuries, drug and alcohol dependency, sexually transmitted infections and/or HIV, severe pregnancy complications, forced or coerced abortions and infertility (WHO et al., 2015a). The extreme physical and emotional trauma puts victims at risk of premature death from homicide, suicide, drugs and alcohol overconsumption, and developing AIDS-related illnesses (ILO, 2008; Conner et al., 2014; Ottisova et al., 2018). Most are not able to get support or help due to their isolation.

There are legal, political and ethical challenges involved in providing services of any kind, including CSE, to people under the age of 18 engaged in the sex industry, since any type of sex work engaging minors is considered to be sexual exploitation from which they should be protected. This should not, however, be used as a justification for keeping young people under 18 from accessing information, prevention and care services. However, in order to avoid any confusion, the recommendations below apply only to those who are aged 18 years or older, and who voluntarily choose to sell sex.

### *Programme planning and development*

- **Seek ethical approval from an advisory body:** Because of the particular complexities of delivering CSE to young people who sell sex, consider seeking an ethical review to confirm that the programme is ethically principled and justified, and to lend it credibility and acceptability. The programme should follow the ethical principles of voluntary participation, confidentiality of information shared and of programme records and data, and referrals for health and other services as needed.
- **Devise a secure system to maintain strict confidentiality:** Protect any personal information about participants from access by individuals, groups or organizations hostile to people who sell sex.
- **Establish a system to assess new entrants to selling sex and identify whether they have been coerced, forced or are under 18 years of age:** This can be done by self-regulating sex worker boards, or in cooperation with individual sex workers. Those who are under the age of 18 or who are unwillingly selling sex should be counselled, supported and referred for social services and health services. Programmes offered must address the different needs of each of the young persons situations as people who are victims of trafficking are very different than for those who are young and entering to selling sex.
- **Seek to identify and engage young people as soon as possible after they start selling sex:** Many people who sell sex begin doing so at a young age, and they are most vulnerable to violence and negative health outcomes during the first months (Onyango et al., 2012; Busza et al., 2016). Programmes should consider that a young person who enters sex work may not at first identify as a person selling sex or a

sex worker. Youth drop-in centres that provide meals, bathing facilities and other services, such as literacy training, may be entry points to identify or reach young people who sell sex (WHO et al., 2015a). Make efforts to reach young men and transgender people who sell sex (Onyango et al., 2012).

- **Link or integrate CSE content with other programmes for young people selling sex:** Young people who sell sex require a combination of biomedical, behavioural and structural interventions to address the many health risks and human-rights violations they may face. As far as possible, provide holistic, people-centred support, which may include providing or referring them to assistance with housing, bathing facilities, food, health care, counselling, services for violence and mental health, education, income-generating opportunities, legal services, parenting support, and social welfare and child protection services, especially for street-based and homeless young people who sell sex (Onyango et al., 2012; Busza et al., 2016). Consistent access to condoms, pre-exposure and post-exposure prophylaxis for HIV, HIV testing, counselling and treatment also need to be ensured (Onyango et al., 2012; WHO, 2016a).

### *Teaching and learning methods*

- **Integrate CSE for young people who sell sex into community empowerment approaches:** This helps to address their stigmatization and marginalization, and is also an opportunity to foster collective empowerment.
- **Do not focus exclusively on sexual and reproductive health topics:** Find different angles to present information that will interest participants (Moore et al., 2014; NSWP, 2016a). For example, talk about pregnancy, prevention of HIV and sexually transmitted infections from the angle of beauty and health, which are important for those selling sex.

### *Programme delivery*

- **If possible, deliver the programme in a centre where participants also have access to other services:** These might include refreshments, showers, rest and recreation. In some places, however, it may be more effective to deliver the programme in the sex workers' homes or places of work, particularly if they live together.

### *Key documents and guidelines*

- *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions* (WHO, 2013)
- *Policy Brief: Young Sex Workers* (NSWP, 2016)
- *HIV and Young People Who Sell Sex: Technical Brief* (WHO, 2015)
- *Empowering Each Other: Young People Who Sell Sex in Ethiopia – a Case Study from the Link Up Project* (Frontline AIDS, 2015)
- *Research for Sex Work 15: Resistance and Resilience* (NSWP, 2016)

### 3.11 Young people in detention

Because there may be significant overlap between children and young people in detention and young people who use drugs, sell sex, or have psychosocial disabilities, the relevant recommendations from those sections of this Guidance should also be considered for children and young people in detention.

Children and young people in detention include those who are involved with the criminal justice system or who are in administrative detention. These include children and young people who are being detained at a police station, in jail awaiting charges or trial, or serving a sentence after conviction, or who are in juvenile, immigration or drug detention centres or rehabilitation centres (IPPF and UNFPA, 2017b). In judicial detention, the decision to detain is made by a judge or court if the young person is charged with or convicted of a criminal offence, whereas in administrative detention, the decision is made by an executive or administrative body.

The number of children and young people in detention worldwide is not known due to the lack of record-keeping and the wide array of institutions in which they may be detained. In 2009, UNICEF estimated that more than 1 million children under the age of 18 were being detained by justice systems at any given time (UNICEF, 2009), but this is likely to be a significant underestimate (Human Rights Watch, 2016). Interrelated factors that may lead to children and young people being in detention include poverty, family problems (including lack of parental guidance), lack of education or employment, violence, and abuse and exploitation (UNODC, 2006).

Children and young people may be detained or imprisoned because they are suspected or convicted of crimes; because they are considered “at risk of delinquency” or a “social nuisance” or in an “irregular” situation; or because of improper or arbitrary actions by law enforcement. Migrant children are also routinely held in immigration detention, contrary to international standards. Children with disabilities and others may be institutionalized in the guise of protection. Reasons for administrative detention also include controlling immigration and cross-border movement, containing those who pose security threats, ensuring treatment for mental-health conditions, containing those using drugs, and protecting those at risk of abuse or exploitation or who would otherwise be living on the street (Hamilton et al., 2011).

Most literature on the CSE needs of children and young people in detention is from high-income countries, but even in these contexts it is clear that they are at risk of poor health and well-being compared with the general population because of higher rates of teenage pregnancy, higher prevalence of sexually transmitted infections and HIV, histories of family violence, trauma

and sexual abuse, high prevalence of mental-health problems and substance abuse, experiences of stigma and discrimination, poor access to health care and education, and low literacy (Schmiege et al., 2009; RACP, 2011; BMA, 2014). These risks can be compounded for incarcerated adolescent girls due to their lower gender and economic status compared with adolescent boys (BMA, 2014). Children and young people are also at risk of sexual abuse while in detention, particularly those who are held with adult detainees (Freudenberg et al., 2010; Human Rights Watch, 2016). LGBQ+ and transgender detainees are at particularly high risk of verbal abuse and physical and sexual violence (James et al., 2016).

Detaining children and young people limits their normal adolescent development and experimentation, because they often have little or no contact with their families, and generally no physical contact with adolescents of the same or opposite sex, and they are in an environment where they cannot assert their independence. Without the opportunity to form relationships and model the behaviour of adults in healthy relationships, in some contexts the normal process of maturation can be delayed or harmed (Commission on Sex in Prison, 2015). Detained children and young people may be fearful about sex and relationships after release, especially if they were abused, and anxious about what future partners will think of their lack of romantic and sexual experience compared with their age peers (Commission on Sex in Prison, 2015). Many children and young people in detention have strained family relationships and peer networks that may include people who use substances, are in conflict with the law, or are delinquent (Moore et al., 2013), and this may influence them negatively after their release.

#### *Programme planning and development*

- **Engage with detention officials from the beginning of programme development:** Detention can be an opportunity to reach children and young people with sexuality education and sexual and reproductive health services that they cannot access in the community. However, because correctional facilities are highly controlled and closed systems, and there may be resistance to allowing programmes that appear to endorse children’s and young people’s sexuality, continual negotiation and understandings with officials at different command levels are needed (Sifunda et al., 2008).
- **Collaborate with other stakeholders:** Preparing to deliver CSE in detention facilities requires intensive and systematic collaboration between programme developers and everyone else involved. This may include facilitators, facility counsellors or therapists, courts, families and collaborating community partners, in addition to detention facility officials (Sifunda et al., 2008; Marvel et al., 2009; Liddle et al., 2011).
- **Consider collaborations with community-based service providers, academic researchers, and detention systems:** Established service providers and researchers may be seen by detention authorities as trusted experts, and their reputation and expertise may help overcome barriers to developing and

evaluating CSE programmes for children and young people in detention (WHO, 2007a).

- **Understand the structural constraints and norms that detention settings impose on children and young people:** Detention settings are often constrained by gender, class, ethnicity or religion, and typically are oppressive and disempowering. The topics and activities within the curriculum should take this into account.
- **Where possible, integrate CSE into comprehensive rehabilitation programmes:** Children and young people are not always in detention: many move in and out of the system, so programmes must address both their current and future needs, on the day they leave and in the months after. The period right after release is a critical time because risks are amplified when children and young people return to the environment where they got into difficulties (which most likely will not have changed in their absence) and reunite with peers and partners. However, release also provides children and young people with the opportunity to apply lessons learned during CSE in detention to the real world. Ideally, CSE should be integrated into a comprehensive re-entry or resettlement plan that includes collaboration among facility educators, counsellors and community providers of services for sexual and reproductive health, substance abuse and mental health (US DOE & DOJ, 2014). The post-detention component may involve providing additional individual face-to-face sessions, education and support by phone; and referrals to community partners and resources. To ensure continuity, the same facilitators should deliver CSE in detention and post-release, where possible (Liddle et al., 2011). Strong mechanisms for following up with participants after their release should be put in place in advance.
- **Be flexible and plan ways to adapt to unanticipated changes and challenges that frequently occur in detention settings:** These include unexpected location changes or session disruptions for security purposes, or for other activities, such as facility-based therapy, head counts, and movements of children and young people among different settings (Goldberg et al., 2009; DiClemente et al., 2014; DOE & DOJ, 2014).
- **Address the multiple risks and issues faced by children and young people in detention:** Sexuality, substance abuse, mental health, delinquency and criminal activity should be addressed in an integrated fashion within CSE, if possible (Marvel et al., 2009). For example, sexuality education can be conceptualized as part of a young detained person's movement towards health, respect for themselves and self-care. It may be advantageous to add or integrate CSE into substance use prevention programmes or sexually transmitted infection and HIV risk reduction programmes, where these exist (Bryan et al., 2009; Marvel et al., 2009; Mouttapa et al., 2009).
- **Use a participatory process to develop the content of the CSE programme by collaborating with the children and young people in detention:** Negotiation may be needed with institutional authorities if they are reluctant to place any control in the hands

of juvenile detainees, but this approach can help programme developers to understand and address the realities of young detainees' lives, what makes them vulnerable, what they need and want, and their beliefs, aspirations and culture (WHO, 2007a). This can help make CSE relevant even for detainees who do not identify education about sexuality as an immediate need.

- **Involve parents, caregivers and families as much as possible in the programme:** This can be achieved through joint sessions, to address familial factors and to encourage family engagement and interactions with children and young people while they are in detention.
- **Involve partners of young people in detention in the programme:** This is especially valuable for male partners of adolescent girls, in discussions of relationships, violence, pregnancy, and prevention of HIV and sexually transmitted infections (Davis et al., 2016).

### *Teaching and learning methods*

- **Provide trauma-informed CSE:** Many children and young people involved with the detention system have a history of family violence, trauma and sexual abuse; and they may experience further trauma within the detention system. (For further details, see p.14.)
- **Use critical pedagogy (see Glossary) to empower participants as individuals and as a community:** It should also be used to help them challenge the social inequalities that shape the lives of children and young people involved with the detention system. In institutions characterized by punishment and hierarchy, such as detention centres and prisons, providing participatory, critical models of CSE may be especially empowering. Participatory education may provide participants with relief from the silencing and dehumanizing conditions of detention. Rather than taking a didactic, disease-prevention approach, programmes should prioritize learning about the contexts of the participants' lives, their survival strategies and the conditions that constrain their decision-making. This will also help to create rapport between the participants and programme implementers (Fields et al., 2008).
- **Use both group and individual sessions** (Davis et al., 2016): Group sessions are preferable when peer interactions, feedback and influence are important, for example with adolescent male sex offenders (Dwyer and Boyd, 2009). Where possible, individual sessions may be used if group sessions are difficult to carry out because of distractions or interruptions, or for material that is more sensitive or that needs to be individualized.

## Programme delivery

- **Train and support facilitators to use skills recommended for juvenile detention settings:** These include positive behavioural interventions, and classroom management techniques to address disruptive behaviours and help students address their social and emotional needs. Ideally, facilitators should be experienced in teaching at-risk children and young people and receive ongoing professional development to improve their skills (US DOE & DOJ, 2014).
- **Use supportive discipline approaches to increase trust between facilitators and participants:** Facilitators must address misbehaviour, using clear, appropriate and consistent expectations and consequences with participants. Participants must feel safe and supported at all times, especially because many of them may not have had positive experiences with educators in the past (US DOE & DOJ, 2014).

## Key documents and curricula

- *Effectiveness of Interventions to Address HIV in Prisons* (WHO, UNODC, UNAIDS, 2007)
- *Interventions to Address HIV in Prisons: Prevention of Sexual Transmission* (WHO, UNODC, UNAIDS, 2007)
- *Healthy Sexual Development of Children in Prison* (Howard League for Penal Reform, 2015)
- *Young Lives behind Bars: The Health and Human Rights of Children and Young People Detained in the Criminal Justice System* (British Medical Association, 2014)
- *Guiding Principles for Providing High-Quality Education in Juvenile Justice Secure Care Settings* (US DOE & DOJ, 2014)
- *United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the "Beijing Rules")* (United Nations, 1985)

## Glossary of Terms

The terms and concepts used in this document reflect widely accepted definitions as well as definitions used in documents prepared by the United Nations and its agencies.

**Adolescent:** A person aged 10–19 years. (A child is a person under 18, and a young person is 10–24 years of age.)

**Agender:** A person who does not identify with any gender.

**Asexual:** A person who does not feel sexual attraction to others, or has a low or absent interest in or desire for sexual activity.

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

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

**Child:** A person under 18 years of age (UN definition).

**Cisgender:** Having a gender identity that is the same as the sex assigned at birth.

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

**Critical pedagogy:** A teaching approach, based on the work of Brazilian educator Paulo Freire, that guides marginalized or oppressed learners to question and challenge prevailing power dynamics and domination and empowers them to take action to change their own situations.

**Curriculum:** A document that defines the learning objectives, standards, content, units and lessons or sessions of a specific course or educational programme.

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

**Detention:** Being deprived of personal liberty except as a result of conviction for an offence (which is imprisonment).

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

**Gay:** A person who is primarily or exclusively romantically and sexually attracted to and/or has relationships with someone of the same sex or gender. Commonly used for males, although some females also use this term.

**Gender:** The socially constructed characteristics ascribed to women or to men, such as norms, roles, attributes, and relationships between groups of women and men and girls and boys. These characteristics are learned through socialization processes.

**Gender-based violence:** Violence against someone based on gender discrimination, gender-role expectations or gender stereotypes, or based on the differential power status linked to gender, that results (or is likely to result) in physical, sexual or psychological harm or suffering.

**Gender expression:** How a person expresses their gender to the world, e.g. through their name, clothes, style, movements and gestures, speech and communication, roles and their general behaviour.

**Gender norms or roles:** Culturally expected, allowed, acceptable, desired or valued behaviours and attitudes based on a person's actual or perceived sex.

**Gender identity:** A person's deeply felt internal experience of their own gender, which may or may not correspond with the sex assigned to them at birth.

**Gender non-binary:** Having a gender identity that is not exclusively male or female.

**Gender non-conforming:** Not following the expected or standard gender roles, norms or expressions for one's gender or for a single gender.

**Gender-transformative approach:** An approach that promotes gender equality and challenges unequal gender roles, norms, relations and status.

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

**Harm reduction:** strategies to reduce the negative consequences of potentially harmful human behaviours, such as drug use or having multiple sexual partners, rather than to eliminate the behaviour.

**Homophobia:** Fear, discomfort, intolerance or hatred of homosexuality and people who are or are perceived to be gay.

**Homophobic violence:** Violence perpetrated towards someone based on their actual or perceived homosexuality.

**Homosexual:** A person whose primary sexual and/or romantic attraction is to people of the same sex or gender.

**Humanitarian crises/emergencies:** Single events or a series of events, such as armed conflicts, epidemics, natural disasters and famine, that threaten the health, well-being or safety of a community or large group of people.

**Inclusive education:** Education that addresses and responds to the diverse needs of all learners and reduces exclusion from and in education.

**Indigenous peoples:** The original inhabitants of a given region – in contrast to groups that have settled, occupied or colonized the area more recently – who have maintained sociocultural characteristics that are distinct from those of the dominant culture of the societies in which they live.

**Informed consent:** Voluntary agreement to do or participate in something or to allow something to be done, such as a medical procedure, with full understanding of the facts, risks, benefits and possible consequences.

**Intersex:** People who are born with biological sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary definitions of male or female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations.

**Key populations:** Population groups that are particularly vulnerable to HIV infection, including gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and prisoners and people in detention.

**Lesbian:** A female whose primary sexual and/or romantic attraction is to people of the same sex or gender.

**Pansexual:** A person who is sexually and/or romantically attracted to people of all gender identities.

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

**People with disabilities:** People who have long-term physical, intellectual, sensory or psychosocial impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

**Privacy:** The state or condition of being free from being observed or disturbed by other people. The right to privacy is the right to be free from interference or intrusion, including unwarranted or excessive unsolicited interventions by the state or other individuals.



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

**Reproductive rights:** The rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, free from discrimination, coercion and violence; to have the information, education and the means to do so, and the right to the highest attainable standard of sexual and reproductive health.

**Safe spaces:** A physical or virtual place or environment in which an individual or group can feel confident that they will not be exposed to discrimination, criticism, harassment or any other emotional or physical harm.

**Self-determination:** The process by which a person controls their own life, free from coercion or force; and their right to do so.

**Serious game:** A serious game or applied game is a game designed for a primary purpose other than pure entertainment, most often for educational purposes. Serious games share some similarities with simulations, for example using storytelling, but use fun and competition to add pedagogical value.

**Sex:** Biological and physiological characteristics (genetic, endocrine and anatomical) used to categorize people as either male or female.

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

**Sexual minorities:** Groups whose sexual identity, orientation, characteristics or practices are different from those of the majority, including people who are not heterosexual and those who are transgender, intersex or gender non-conforming.

**Sexual orientation:** A person's sexual identity in terms of the sex/gender or sexes/genders to which they are sexually and/or romantically attracted, including to individuals of a different sex/gender (heterosexual), the same sex/gender (homosexual), more than one sex/gender (bisexual or pansexual) or no one (asexual).

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

**Transgender:** A person whose internal sense of their gender (gender identity) differs from their sex assigned at birth. Transgender people may identify as male, female, a combination of genders or no gender.

**Transphobia:** Fear, discomfort, intolerance or hatred of people who are or are perceived to be transgender.

**Transphobic violence:** Violence perpetrated against someone because they are or are perceived to be transgender or gender non-conforming.

**Trauma-informed approach:** An approach that fully integrates knowledge about trauma into policies, procedures and practices and actively seeks to prevent re-traumatization.

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

**Young person:** A person between 10 and 24 years of age.

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