BACKGROUND PAPER FOR CSE AND YFHS LINKAGES YOUTH WEEK: 26-30 SEPTEMBER 2016

Introduction: The Knowledge Platform on the SRHR and HIV (Share-Net international), in its vision, works toward making a visible difference in closing the gap between knowledge, policy and practice in the field of SRHR and HIV with particular reference to: 1) Better information and greater freedom of choice for young people about their sexuality; 2) improved access to reproductive Health (RH) commodities; 3) better Sexual Reproductive Health (SRH) care (during pregnancy and childbirth, including safe abortion); and 4) greater respect for the Sexual Right (SR) of groups who are currently denied their rights. Keeping these visions in mind, and as part of its ongoing efforts, Share-Net is hosting a 'Youth Week' (26-30 September) to bring together SRHR community to share and learn the knowledge and lessons from practices on the linkages between Comprehensive Sex Education (CSE) and Youth Friendly Health Services (YFHS), and to broaden the discussion on gender, Gender Based Violence (GBV) and Sustainable Development within the frameworks of Sustainable Development Goals (SDG) (especially SDG 3 and 5). To get the Youth Week discussion started and to set the research and advocacy agenda - this Background paper aims to address the following issues:

a. To provide a historical overview of the critical development in thinking about CSE and YFHS;
b. An overview of existing knowledge about linkages between CSE and YFHS;
c. Reflect on knowledge translation to knowledge use through evidences;
d. What research questions still exist?

The paper is, therefore, structured keeping the above mentioned questions and objectives of the Youth Week in mind.

SECTION 1: HISTORICAL OVERVIEW OF THE CRITICAL DEVELOPMENT OF CSE AND YFHS

1.1 COMPREHENSIVE SEX/UALITY EDUCATION (CSE): What knowledge Exists?

An unprecedented 1.8 billion youth are alive today (in a world population of 7.3 billion) and among them adolescents have never in the past represented such a large segment of the population and about 89% or nine out of ten people between the ages of 10 and 24 live in less developed countries – and the percentage is even higher in the youngest range of the age category. Also to remember that international migrants aged 10-24 constituted over 12% of world's total 232 million international migrants in the year 2013, which has increased in many fold in recent times (UNFPA 2014)[i]. Understandably, adolescents as a category has emerged to be one of the most significant group in world development discussions. But, firstly, who is an Adolescent? And *what is Adolescence?* – These are the two most pertinent questions to be asked here. Interestingly enough, the concept of adolescence as a distinct life stage is relatively new in many developing countries compared to the situation in the developed world where the concept of adolescence as a life stage with legal boundaries has been recognized since the late 1800s/early 1990s. Historically, G. Stanley Hall's two-part text of 1904 titled "Adolescence: its psychology and its relations to anthropology, sex crime, religion and education" is recognized for popularizing the use of the term "adolescent" and heralding the recognition of adolescence in the industrialized world as a vulnerable and malleable group deserving of special attention. On the whole, adolescence as is currently known in current terms is a product of

modernity, influenced mainly by education, industrialization and urbanization (Fatusi and Hindin, 2010)[ii]. World Health Organization (WHO) identifies adolescence as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to19. It represents one of the critical transitions in the life span and is characterized by a tremendous pace in growth and change that is second only to that of infancy. (World Health Organization, Para. Maternal Child Adolescent) The United Nations Population Fund (UNFPA) also provides a similar definition of Adolescence.

Another important question that is often asked, is, *Are Adolescents Children?* According to the 1989 Convention on the Rights of the Child (CRC) — "a child is any human being below the age of eighteen years, unless under the law applicable to the child, majority is attained earlier." This definition almost overlaps with the current definition of adolescence (10 - 19 years of age) in general, therefore Adolescents can be considered as children. Rights of the Child protects the Child as a human being, and guarantees access to all the fundamental human rights including civil, political, economic, social, cultural, individual and collective rights. This blurry lines between legal definitions of adolescents and children, is particularly of our interest when it comes to SRHR, CSE and YHFS issues because negotiations over rights, entitlements and services versus cultural norms and appropriateness which are highly contextual and controversial.

The correlations between high proportion of young people in populations and barriers to development create a vicious circle of poverty, discrimination, violence and poor life choices and chances for the young – and all this has direct impact of young people's, including adolescents' sexual and reproductive health and rights which is marred with gender discrimination, gender based violence and poor life qualities for many. For example, every year 15 million girls are married before the age of 18, which means 1 in every 2 seconds (Girls not Brides, 2016)[iii], or the fact that early pregnancy and child birth is the second leading killer of females aged 15-19, while the leading cause of adolescent girls is suicide which indicates to the most unaddressed issue of mental health of this age group worldwide. Adolescents account for 23% of the overall burden of disease (disability-adjusted life years) because of pregnancy and childbirth (Patton, G.C., Coffey, C., Sawyer & S.M., 2009[iv]). An estimated 16 million births annually occur to young women aged 15–19 years, representing 11% of all births (Sawyer et al. 2012[v]). Almost all (95%) of adolescent births take place in developing countries. Approximately 2.5 million births occur to girls aged 12–15 years in low-resource countries each year (Neal, S., Matthews, Z., Frost, M., 2012[vi]). Early childbearing is linked with higher maternal mortality and morbidity rates and increased risk of induced, mostly illegal and unsafe, abortions. Gender-based violence is an all too common reality for many adolescents, especially girls. Globally, an estimated 30% of adolescent girls (15–19 years) experience intimate partner violence according to recent World Health Organization estimates (World Health Organization, 2013). An estimated one million young people aged 15–24 years are infected with HIV every year representing 41% of all new infections among those aged 15 years and older (UNAIDS, 2010[vii]). In one word, a quick glimpse at all the available data, indicates that investing in Adolescent Sexual and Reproductive Health and Rights (ASRHR) is actually a matter of public health, human rights, and economy – i.e. progress and development of every country.

ASRHR is part of overall well-being of adolescents and that includes mental health. It has been pointed out by experts that poor sexual and reproductive health outcomes in poor mental health (Barry et al. 2013). On the other hand HIV is the second leading cause of adolescent death in contrast to maternal mortality (UNFPA 2014). Therefore, without a doubt, adolescence is a phase that holds immense promises for the future as well as harbors great risks. While adolescents all over the world confront distinct vulnerabilities during this phase of transition, gendered experiences can be different (from country to country, from cultural context to context) and can bring specific types of risks and vulnerabilities for girls, in particular. Sexual and reproductive health and rights (SRHR) is considered as one of the major pathways to adolescent and young peoples' realization of full life potential and growth as individuals as well as members of the collective. SRHR is seen as an integral and crucial part of adolescent wellbeing, which cannot be seen (in policy or practices) as an isolated aspect of developmental interventions, but rather in a holistic approach that integrated through and with adolescent and young peoples' access to quality and life oriented education, through their active participation and engagement is every decision making processes that is relevant to their lives; having access to youth friendly and appropriate affordable SRHR services; and finally having the chances and promises of better livelihood to function as adults. Information, services and opportunities guarantees empowerment and empowerment ensures healthy happy sexual and reproductive health and rights for young people.

'*The danger of ignorance versus the danger of education*' (Carter 2001:248) – the perennial tension of Sex education

As adolescent health has become a much concerned area for global development issues, especially when it comes to the SRHR. Access to quality information and services in SRHR for adolescent(and young people) and its significance in ensuring their better life choices and chances is at the core of discussions related to Comprehensive Sex Education (CSE) and Youth friendly Health Service (YFHS). On one hand, development in information and communication infrastructure all over the world has led to youths getting easy access to internet and are increasingly becoming exposed to sexually explicit contents (UNESCO, 2009). On the other hand lack of proper sex education in schools and orientation in families are putting adolescents in the threat of engaging in risky sexual activities that may lead to Sexually Transmitted Infections (STIs) and Sexually Transmitted Diseases (STDs). Sex Education (SE) has an interesting and contested history to it, within which CSE is embedded and has tried to emerge from. Sex education, since the enlightenment, in the west, has been part of a process through which children were guided into adulthood, but the history of sex education through sexual pedagogy coincides with rise of formal or mandatory state-sponsored schooling and increased enrollment of students past the age of puberty. Tracing the history of sex education in the USA (between 1910-1940), Carter, (2001), shows how the increasing concern about transmission of venereal disease brought about a widespread public conversation about sex education/knowledge in relevance to STIs. Therefore, from the early days, 'public funded sex education has emphasized the close connection between individual conduct and the common weal' and 'Caught between the desire to shape sexual activity and the fear of stimulating it, between the wish to enforce some forms of sexuality and the dread of accidentally fostering others, sex education occupied an uncomfortably ambivalent epistemological field (Carter 2001:216-217).[viii] As a result of such dilemma and ambivalence,

sex education, which became part of developmental education[1], focused on "the birds and the bees" which allowed it to evade any direct engagement with human sexuality and thus resulted in teaching sex without inadvertently introducing young students to desire – with the hope that such non-humanized content and approach to sex education would have the desired influence of young peoples' sexual behavior and morality and the consequences of such education could still be controlled and contained within the desired moral framework of the society. Interestingly, and perhaps not surprisingly, SE of this era based itself heavily on establishing strict patriarchal gender roles and norms and establishing masculinity over 'weaker' femininity, and protection of the 'innocence ' of, especially the feminine kind, was seen as crucial outcome of SE (Carter 2001). This approach, i.e. SE based on bio medical, disease centered and gender normative through distant and ambivalent teaching methods, 'The knowledge of contagion represented sex as a pollutant and a moral scourge, at the same moment that it argued for its value as the foundation for happy marriages and a healthy civilization' (Carter 2001: 233) - still resonates with various versions of SE around the world today. Similar studies in Europe finds that in the twentieth Century, European societies acknowledged the necessity of teaching sexual knowledge to young people so that they could be educated in the matters of socially accepted sexual moral behavior. Sweden and West Germany were the front runners, while England, Scotland, Italy or Poland introduced it in the mid twentieth century – but nevertheless, the content and method of teaching SE remained a contested issue as ever. 1960s liberal environment created a favorable environment for more liberal philosophical approach to SE by detaching itself from Christian values, or disassociate it with family or marriage norms, but rather teach it through purely medical perspective and with sexual and reproductive anatomy. But the contestations regarding where should a child get SE (home versus school), how far a child should be informed about sex, body, desires; how would religious and social morality and norms be embedded or even guide the content, or method of teaching; and with increasing influence of media and other sources of information – how should SE shape its format – remained and remains a debatable issue even today (Sauerteig and Davidson, 2009[ix]; Alldred and David, 2007[x]).

Sex Education, like all other matters under SRHR is a highly political and controversial issue. SE is often positioned within antagonistic discourses, and these discourse cut across sectors and arenas like education, political science, religious studies, as well as national and local politics. The various contested approaches to SE, like Abstinence Only (AO) versus Comprehensive Sex Education (CSE) is a highly political, multi-dimensional and an intriguing one. These two approaches dominate the curricular landscape and the educational politics of sex education as AO is considered to be 'traditional' (often termed as backward, conservative religion infused result of public policy) and CSE as 'Modern'(scientific, accurate, freedom and agency (Lesko, 2008)[xi]. Studies comparing AO and CSE curriculum (mostly in the West) show that AO is based on the following principles like: Sex Respect: The Option of True Sexual Freedom is an abstinence-only-until-marriage; Feeling sure, Feeling safe, Feeling self-controlled and free, and Nostalgic longings; while CSE works with: Feeling scientific, Feeling positive, Feeling free (Lesko 2010; Collins, Alagiri, Summers, 2002[xii]). A comparative debate on the merits and demerits of both the approaches is beyond the scope of this paper, for which it will now move the discussion solely on CSE.

[1] Knowledge of development offered a vision of sex as a part of a lively and wholesome natural world. Carter, 2001

CSE: Why-When-What?

The concepts of SRHR were adopted for the first time by governments under the aegis of the United Nations at the International Conference on Population and Development (ICPD) in Cairo in 1994. ICPD laid out a bold, clear, and comprehensive definition of reproductive health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations, 1995). The ICPD helped to bring focus on adolescents and young peoples' SRHR issues globally. It brought focus on the importance of integrated education and service providing systems that can cater to the physical, mental and overall wellbeing of adolescent and young people, in order for them to be responsible regarding sexuality. Confirming the critical importance of adolescent sexual and reproductive health and rights (ASRHR), the Commission on Population and Development in 2012 issued resolution included the right of young people to Comprehensive Sexuality Education (CSE). Since then, various agreements and lobbying efforts, on the basis of common understanding of ICPD (+5 and +20), are made to emphasize on the fact that CSE is not only to impart sex education, but must incorporate gender relations and equality, promoting wellbeing and responsible sexual behavior, and protection against sexual violence, and abuse (Chandra-Mouli et al., 2015[xiii]; Haberland and Rogow 2014[xiv]). In 2009 and 2012, the Commission on Population and Development reaffirmed this, approving resolutions that called upon governments to provide young people with comprehensive education (Haberland and Rogow, 2014).

In alignment with the 1994 International Conference on Population and Development (ICPD) Programme of Action, the Commission on Population and Development (CPD)–CPD 2009, Resolution 2009/1, para 7; CPD 2012,Resolution 2012/1, para 26 and UNESCO's International Technical Guidance on Sexuality Education (ITGSE), among other international agreements, UNFPA defines "comprehensive sexuality education" as a right-based and gender-focused approach to sexuality education, whether in school or out of school. CSE is curriculum-based education that aims to equip children and young people with the knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality, in the context of their emotional and social development. By embracing a holistic vision of sexuality and sexual behavior, which goes beyond a focus on prevention of pregnancy and sexually transmitted infections (STIs), CSE enables children and young people to a) Acquire accurate information on sexual and reproductive rights; b) Develop life skills; c) Nurture positive attitudes and values Open-mindedness (UNFPA 2014)[xv]. Similarly, IPPF's Framework for Comprehensive Sexuality Education includes the principles of good practice, complements existing CSE programs and guidelines, describes the seven priority areas to cover in CSE; focuses on the rights and needs of young people and provides the basis of a new CSE curriculum. A rights-based approach to Comprehensive Sexuality Education seeks to equip young people with the knowledge, skills, attitudes and values they need to determine and enjoy their sexuality – physically and emotionally, individually and in relationships. It views 'sexuality' holistically and within the context of emotional and social development. It recognizes that information alone is not enough. Young people need to be given the opportunity to acquire essential life skills and develop positive attitudes and values. Comprehensive

Sexuality Education must help young people to: The Seven Essential Components of CSE are: 1) Gender; 2) Sexual and Reproductive Health and HIV; 3) Sexual Rights and Sexual Citizenship; 4) Pleasure; 5) Violence; 6) Diversity and 7) Relationships (IPPF 2007).[xvi]

1.1.2 CSE: *What works or not? Evidences and discussions*

In 2013 World Health Organization, in partnership with the International Women's Health Coalition and the United Nations Population Fund, organized an Expert Group Meeting to review the current evidence on ASRHR (also to examine the progress made in policies and programs in the 20 years since the ICPD; and discuss and identify implications for implementing the ICPD PoA beyond 2014 and for the post-2015 agenda). The themes selected for this were to cover five complementary and inter-related intervention areas to promote ASRHR. The five themes were:

- Creating an enabling environment for ASRHR: What do we know about what works?
- *Providing CSE: emerging trends in evidence and practice.*
- Providing adolescents SRH services and increasing adolescent demand and community support for their provision.
- Addressing intimate partner and sexual violence among adolescents: emerging evidence of effectiveness.
- Ensuring youth's right to participation and the promotion of youth leadership in the development of SRH policies and programs.

The review indicated that there was a lack of enabling environment to effectively implement adolescent SRHR programs, especially in implementing CSE and in reaching out to young adolescents between the ages of 10-14. In recent times, there has been a considerable number of reviews of CSE and evidences show some positive impacts of such programs. For example, Kirby, Laris and Rolleri (2006)[xvii] reviewed 83 studies that measured the impact of curriculum-based sex and HIV education programs (of which six were AO and all in the USA) on sexual behavior and mediating factors among youth under 25 years anywhere in the world. Overall, these studies strongly indicated that curriculum based programs have more positive impact on behavior of young people than a negative one. Two thirds (65%) had a significant positive impact on one or more of these sexual behaviors or outcomes, while only 7% had a significant negative impact on one or more of these behaviors or outcomes. One third (33%) of the programs had a positive impact on two or more behaviors or outcomes. The researchers' findings were also similar in both developed and developing countries – which is an interesting observation for the debate on resource versus quality in SRHR programs. Also programs were seen to be effective with both low- and middle-income youth, in both rural and urban areas, with girls and boys, with different age groups, and in school, clinic, and community settings. But it is also to remember that this does not mean that the same program was effective with all of these groups in all of these areas, but simply that different programs were effective with all of these groups in all of these areas. The six AO programs in the USA showed few positive results (and one negative result), just like the many positive results and a few scattered negatives results for the various other non-AO programs that emphasized both abstinence and condom or contraceptive use. The researchers' in depth analysis of these

vast number of programs around the world *identified 17 characteristics (Annex 1) a*nd three types of evidence suggested that these characteristics may have contributed to the success of these programs. Comparative study showed more impact of skill-based curricula that incorporated all (or nearly all) of these characteristics with the impact of knowledge-based curricula. Consistently, the skill-based programs were more effective at changing behavior than were the knowledge based programs. Kirby (2008) in another study on 'The Impact of Abstinence and Comprehensive Sex and STD/HIV Education Programs on Adolescent Sexual Behavior' (56 studies reviewed) indicated that while most abstinence programs did not have any significant positive effects on any sexual behavior, about two thirds of comprehensive programs showed strong evidence that they positively affected young people's sexual behavior, including both delaying initiation of sex and increasing condom and contraceptive use among important groups of youth (2008:18)[xviii]. UNESCO noted that sexuality education can be delivered through a range of programming modalities, including: family life education (FLE), population education, sex and relationships education, SRH education and life skills education, or through dedicated sexuality education programmes. Based on Kirby et. Al. (2006) research, it developed a guideline for effective sex education program and outlined a list of 18 Characteristics (Annex 1) of such program[xix].

Research by Kohler, Manhart, and Lafferty (2007)[xx] , on the role that sex education plays in the initiation of sexual activity and risk of teen pregnancy and sexually transmitted disease (STD) in the United States, showed that adolescents who received CSE were significantly less likely to report teen pregnancy than those who received no formal sex education, but interestingly there was no significant effect of AO education. Abstinence-only education did not reduce the likelihood of engaging in vaginal intercourse but comprehensive sex education was marginally associated with a lower likelihood of reporting having engaged in vaginal intercourse. Neither abstinence-only nor comprehensive sex education significantly reduced the likelihood of reported STD diagnoses. Also was found that In addition, a strong relationship between family intactness and receiving sex education. Teens from intact families were more likely to receive formal sex education than teens from non-intact families. In addition to these, the study indicated that the opportunity for formal sex education appears to vary by social strata, with disadvantaged youth being the least likely to benefit from formal programs. Similar studies in the USA, like one by Eisenberg, et al. (2007)[xxi] which looked into the perspectives from Parents of School-Age Youth, showed parents support for CSE to be high across all groups and typologies of parents, though significant differences emerged across religious groups, Born Again status, public/private school status, political orientation, and income. Furthermore, most parents believed instruction should begin in middle school or earlier for almost all topics. The study also raised the question of a mismatch between what parents wanted to be taught in classrooms, and what has evidence of effective health promotion, and what was actually taught in school-based sexuality education programs. Similar studies (Johnson et al. 2011[xxii], Kathrin et al. 2011,[xxiii] and Constantine et al. 2015[xxiv], Simovska and Kane, 2015[xxv]) around the world have indicated that CSE holds a comparatively higher degree or level of effectiveness in providing knowledge and information to adolescent about SRHR issues (over other traditional approaches).

In other non-Western and often resource poor contexts, CSE has been evaluated to be more effective to create a positive impact on adolescent and young people. For example, research in China, Wang, et al.

(2005)[xxvi], showed potential of CSE in better SRHR knowledge and practices. It indicated that large- scale, community-based interventions have the potential to make an impact on unmarried youth in areas where a high proportion of youth are engaged in sexual activity. Providing CSE and reproductive health services to unmarried Chinese youth may help reduce rates of sexual coercion (the intervention showed association with reduced occurrence of sexual coercion especially among male students and had better negotiation skills related to sexual decisions), promote increased contraceptive use and help decrease rates of unwanted pregnancy. Third, life skills training, contraceptive education and contraceptive distribution are important components of comprehensive sex education programs in highly developed regions in China. Thato, Jenkins & Dusitsin (2008)[xxvii], studied the impact of a Culturally Sensitive CSE Program (CSCSEP)[2]. The findings suggested that effective CSE can occur in specific cultural context (i.e. Thai) with professional facilitation and that such program, is to be made as culturally sensitive and developmentally appropriate intervention devised specifically for adolescents of a specific given socio-cultural background. It showed success in using Cognitive social learning theory and ways in which school and public health nurses could play important roles in education aimed at the prevention of sexual risk behaviors at earlier ages, rather than waiting until most young people are sexually active. The results demonstrate that the CSCSEP students were statistically significantly more likely to delay sexual initiation; sexually active adolescents in this group reported statistically significantly lower frequencies of sexual intercourse; increased intention to use condoms the next time when having sex among both sexually experienced and inexperienced students. CSCSEP students showed higher levels of knowledge about STIs, HIV/AIDS, and pregnancy and also reported increased intention to refuse sex across time.

CSE through newly developed programs like The World Starts with Me (WSWM) combines sexuality education with learning IT skills. This comprehensive program helps young people to address sensitive issues around love, sexuality and relations. The issues vary from the development of their bodies to pregnancy, contraceptives, HIV and sexual abuse. Sexuality, reproductive health and loving relationships are beautiful parts of being human and we approach these serious topics positively. Currently, the World Starts with Me is used in 11 countries in Africa and Asia. In every country, the curriculum is adapted to young people's needs in that specific culture and setting. In 2010 UNESCO's International Technical Guidance on Sexuality Education recommended The World Starts With Me as one of 18 programmes worldwide that is truly comprehensive (Rutgers International, 2016)[xxviii]. In case of Uganda, as shown by Rijsdijk et al. (2012)[xxix] , how WSWM, have significant positive effects on beliefs regarding what could or could not prevent pregnancy, the perceived social norm towards delaying sexual intercourse, and the intention to delay sexual intercourse. There were positive effects of WSWM on attitudes, self-efficacy and intention towards condom use and on self-efficacy in dealing with sexual violence (pressure and force for unwanted sex). The study showed an intervention effect on a number of socio-cognitive determinants. To have greater impact, it is crucial to ensure the role of teachers to guide and coach the students through the 14 lessons, facilitating the process of learning, coaching students to explore opinions, and practicing skills. In order for programs to be faithfully implemented, it is important that teachers are properly trained

[2] CSCSEP was guided by behavior change principles derived from cognitive social learning theory and from international studies of effective sex education programs.

and committed to the program. Since the program is technology based, the issue of resources (like computers and electricity) becomes central to its success. In case of Uganda, it was seen that, in practice, the use of computers for WSWM appeared to be very limited as most schools did not have enough computers, or if there were any, they had to be shared by a group of students (sometimes up to 50) at the same time. Also, broken computers and lack of electricity were major implementation problems faced by most of the schools. Leerlooijer et al.(Year)[xxx] shows that the systematic adaptation of 'The World Starts With Me' program from Uganda to Indonesia successfully resulted in bringing changes because of how the programs while keeping the basics intact, was made to fit the needs of its priority groups as well as meeting its objectives/goals. It is evident that many such problems need to be addressed in a more structural way if the program could be part of the school curriculum. Important to note that success of such programs depend on fidelity to implementation, as findings show that the effects of intervention disappeared for those schools that did not complete the program in time, and the fact that schools where the teacher did not implement the program fully according to the manual were slightly more effective than those schools that did stick to the manual. Socio-cultural (e.g. condom use among young people is a taboo, so teachers are reluctant to promote condom use), political (e.g. homosexuality is a criminal offence, so it is impossible to talk about homosexuality as a human right) and economic (e.g. schools do not have a lot of money to spend, so the use of computers is low; time constraints) characteristics of the context might either facilitate or prevent sound implementation of the program (ibid pp.12).

In other African contexts, like in Nigeria, research in recent times (Huaynoca, Chandra-Mouli, Nuhu Yaqub & Denno, 2013)[xxxi] looks into the 'what worked' for of scaling up of CSE at a national scale. Nigeria's success could be identified in five ways: Firstly, CSE met an expressed need in the country and it was endorsed by national and international experts based on strong evidence: Nigeria developed its CSE curriculum with precise plans in terms of curriculum content, methods and means. The curriculum was simplified to the greatest extent possible. Secondly, multi sector actors' (starting from youth to NGOs, to teachers and community) expertise were engaged to lead different, but complementary, components of a complex innovation. Thirdly, political commitment, championship and advocacy teaming up with learnings from grass root experiences. Fourthly, the proactive, energetic and ongoing advocacy work of state-level Advisory and Advocacy Committees whose members included representatives of key stakeholder groups was crucial in creating public support and preventing backlash. Finally, decisive, well planned management, monitoring and evaluation system in place. Management was decentralized, had a sound funding model that was put in place.

Undoubtedly CSE has great potential to provide young people with the necessary information about their bodies and sexuality, to reduce misinformation, shame and anxiety, and to improve their abilities to make safe and informed choices about their sexual and reproductive health and having access to CSE may contribute to a reduction in early childbirth, (unsafe) abortion, sexual violence and sexual ill health, and to the promotion of gender equality and young people's overall sexual and reproductive health and rights. CSE can help adolescents to transition to healthy, happy and empowered adulthood reaching their full potential as individuals as well as citizens. But it is also true that sexuality education has remained controversial, and its various approaches continue to be debated upon. Evidences discussed above from

around the world show ample evidences of the positive effects of CSE on young people's lives and behavior. Of course, evidences also point towards many limitations in the content, implementation and delivery of these programs – and lack of scientific evidences also remains one of the limitations for us to have access to in depth knowledge for policy lobbying and scaling up. Within the development field, advocates of CSE as part of ASRHR, has been criticized for being optimistic for the incorrect underlying assumption that individual decision-making is the key site of risk minimisation and progress towards sexual health (Vanwesenbeeck et al. 2015)[xxxii]

As Chandra-Mouli, Lane and Wong (2015) mentioned in their review of 'What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices'[xxxiii] since ICPD in 1994, awareness and understanding of SRHR needs and concerns of adolescents, especially in low and middle income countries has increased with time. Policies and programs have learned various effective ways of responding to diverse contexts, norms and needs of this age group. In the past 20+ years, the progress and commitment to ASRHR has been increasingly promising, though there remains many gaps in knowledge and understandings. One of the more successful and effective program approaches has been CSE, which has shown evidences of being impactful in improving adolescent SRHR knowledge, attitude and behaviors – if implemented well. Guidelines on CSE programs, like that of UNESCO (2009), and systematic reviews of CSE programs (like the ones discussed above) prove that rights-based approach that incorporate empowerment approach with it, emphasizing on gender and rights are effective in improving adolescent knowledge and practices of sexual and reproductive lives.

1.2: Youth Friendly Health Services (YFHS): What knowledge exists?

Youth Friendly Health Services (YFHS) has come to be considered as one of the effective ways of delivering SRHR knowledge, information and services to adolescents and young people all over the world. YFHS has been in discussion for a while and there are many operational guidelines and definitions for the concept. *UNFPA*[xxxiv] identifies that YFHS should include: Universal access to accurate sexual and reproductive health information; a range of safe and affordable contraceptive methods; sensitive counselling; Quality obstetric and antenatal care for all pregnant women and girls; and the prevention and management of sexually transmitted infections, including HIV. Services are youth friendly if they have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of young people, and are able to retain their youth clientele for follow-up and repeat visits. They identified and defines YFHS as having the following characteristics: Specially trained staff, Respect for young people, Privacy and confidentiality honored, Adequate time for client and provider interaction, Peer counselors available Health Facility Characteristics, Separate space and special times set aside, Convenient hours, Convenient location, Adequate space and sufficient privacy, Comfortable surroundings. A YFHS program should have: Youth involvement in design and continuing feedback; Drop-in clients welcomed and/or appointments arranged rapidly; No overcrowding and short waiting times; Affordable fees; Publicity and recruitment that inform and reassure youth; Boys and young men welcomed and served; Wide range of services available; Necessary referrals available (Senderowitz, Hainsworth, and Solter 2003[xxxv]). *WHO*

(2012)[xxxvi] recognizes that adolescents are a heterogeneous group and that the expectations and preferences of different groups of adolescents are therefore different. It is interesting to note, however, that different groups of adolescents, from various parts of the world, identify two key, common characteristics. They want to be treated with respect and to be sure that their confidentiality is protected.

In 2007, WHO's recommendation was reiterated in a paper published in The Lancet. Based on an updated review of the literature the authors concluded: '*Enough is known that a priority for the future is to ensure that each country, state and locality has a policy and support to encourage provision of innovative and well-assessed youth-friendly health services*' (Tylee et al. 2007).[xxxvii]Since then, there have been many changes, both in approaches as well as in delivery in making YFHS models inclusive, sustainable and popular. *Fowler, C. I. (2016)*[xxxviii] revisited *WHAT ARE "YOUTH-FRIENDLY" SEXUAL HEALTH SERVICES?* - if they have policies and attributes that attract youth to the facility or program, provide a comfortable and appropriate setting for serving youth, meet the needs of youth, and are able to retain their youth clientele for follow-up and repeat visits. Such services should include: easy access, Welcoming settings, respectful and equitable treatment, confidentiality and privacy protection, comprehensive and evidence based care. What can make health services adolescent friendly? Very much similar to earlier assumptions: that health service providers are non-judgmental and considerate in their dealings with adolescents; and they have the competencies needed to deliver the right health services in the right way. Health facilities are equipped to provide adolescents with the health services they need; and are also appealing and 'friendly' to adolescents. Adolescents are aware of where they can obtain the health services they need, and are both able and willing to do so when needed. Community members are aware of the health-service needs of different groups of adolescents, and support their provision.

In other words, keeping the adolescents' needs at the center, YFHS builds up an integrated system of community, health and education facilities and an enabling environment that allows these young people to seek information and services related to their SRHR lives. Therefore, Adolescent-friendly health care purportedly addresses five domains; equity, effectiveness, accessibility, acceptability, and appropriateness of care. Equity of care relates to the right of all young people to obtain quality care. Effectiveness corresponds to the expected improvement in adolescent health outcomes when care is delivered in the right way at the right time. The other three domains relate to how health care should be provided in order to engage young people (A.-E. Ambresin et al. 2013).

2.1.2 YFHS Evidences: Protectionist Discomfort versus Adolescent Agency

As early as 1998, (soon after ICPD), we see discussions starting on how to meet the growing need of the adolescents and young regarding their sexual and reproductive health rights. Hughes and McCauley (1998)[xxxix] stated, '*Despite the near-universal adult discomfort with the subject, consensus has begun to build in many countries that young people need expanded information, skills, and services concerning sexual and reproductive health'* (1998:233). Interestingly they observed that reviews, conducted by academic experts from various disciplines, and program experts, revealed two overall conclusions about effective programming: First, a broad and strong consensus exists concerning many elements of what constitutes best practice, based on practice, not science. Second, the research knowledge base concerning program effectiveness is weak, especially for developing countries (Ibid. 234). They looked into this matter of

growing demand and lack of scientific evidences (at that point) about program approaches that are effective in shaping 'healthy behaviors' of the adolescents, especially in developing countries. In order to guide planners of such programs, their research indicate that the then current programs often did not match the needs and health seeking behaviors of young people. The challenge lied in the fact that there was a gap between availability of finances and human resources, and the demand of a great size of the youth population – which meant that programs needed to find less costly ways to reach young people. Studies of teachers and health-center personnel indicate that these adults are also unprepared to discuss sexuality with adolescents, often because they feel uncomfortable or overworked, or because they disapprove of young people who express an interest in sexuality. Research and program experience also indicate that adolescents are not always in a position to control the choices they make, including the decision to choose healthy behavior. Although clinics might seem a logical source for information and services, they are not always helpful to adolescents. Young people do not avoid clinics because they have no unfulfilled sexual or reproductive health needs. When they can find sources of accurate, confidential information, they use them.

At that time there were mutually contested debates about various theories and approaches took place (Health-belief model and Social Learning theory versus Adolescent-development theory), and most adolescent SRHR programs were small in scale, linked to other programs, and often these programs did not include skills development or counselling, for example (ibid. 235). Schools, media and clinics – offered limited information and services to adolescent and young people. Against such context, the researchers came up with some suggestions: a. Younger target groups (for example, adolescents who have not yet begun having intercourse receive relatively little attention from those concerned about sexual and reproductive health programming for young people. This group includes primarily younger adolescents; b) Adolescents who have engaged in intercourse like married or in consensual unions, needing antenatal, obstetric, and postpartum care. For program approaches, they suggested six principles which are intended to offer guidance for identifying needs and available resources and linking and strengthening a wider-than-usual variety of content, providers, and settings to create appealing, flexible, effective, and sustainable programs at significant scale. The six programming principles are: 1) Recognize and address the fact that the program needs of young people differ according to their sexual experience and other key characteristics. 2) Start with what young people want and with what they are doing already to obtain sexual and reproductive health information and services. 3) Include building skills (both generic and specific to sexual and reproductive health) as a core intervention. 4) Engage adults in creating a safer and more supportive environment in which young people can develop and learn to manage their lives, including their sexual and reproductive health. 5) Use a greater variety of settings and providers— both private and public, clinical and nonclinical—to provide sexual and reproductive health information and services. 6) Make the most of what exists. Build upon and link existing programs and services in new and flexible ways so that they reach many more young people.

In answering what kinds of programs work, the answer was that most of the needs of adolescents could be met in community settings of young people preference. Programs must be flexible in meeting, at reasonable cost and in sufficient number, the various needs of young people. Communities, planners, and

programmers should collaborate in trying many different approaches and models and promote careful evaluation to determine which designs or components lead young people to adopt healthy behaviors.

In a systematic review of peer-reviewed and gray literature on comprehensive adolescent health (CAH) programs (1998–2013), including sexual and reproductive health services, Kågesten et al.(2014[xl]) concluded that the long-term impact of many CAH programs cannot be proven because of insufficient evaluations. Comprehensive approaches move beyond sexuality education curriculums, contraceptive distribution programs, and abstinence-only programs to build a package of services and programs that target the root causes of sexual health risk and early pregnancy. Such strategies are based on an understanding of health and development in which adolescents are nested in a network of contexts (peers, community, health services, schools, families), suggesting that comprehensive approaches hold the greatest promise. However, little is known about the range, scope, or common activities of such programs and whether such strategies can successfully improve adolescent SRH. Their results show that over the past 15 years, a wide range of self-identified comprehensive adolescent health programs have been implemented in countries around the world; however, few have been sustained over a long period. Many programs do not have publicly accessible documentation of activities; consequently, it is not possible to replicate them. The results of this review indicate that comprehensive adolescent health programs that combine high-quality sexual and reproductive and other health services with educational and social support mechanisms can positively influence adolescent SRH. Common elements such as long-term commitments to adolescents, building human connections, engaging key community stakeholders, and use of skill-building activities cut across all rigorously or strongly evaluated programs

Fast forward contemporary times and the question remains the same*: Is there any evidence that efforts to make health services adolescent friendly can increase their utilization by adolescents?* There is growing evidence for the effectiveness of some of these initiatives in improving the way health services are provided, and in increasing their use by adolescents. In 2006, WHO published a systematic review of the effectiveness of interventions to improve the use of health services by adolescents in developing countries.10 This review identified twelve initiatives, including one randomized controlled trial (Nigeria), six quasi-experimental studies (Bangladesh, China, Madagascar, Mongolia, Uganda and Zimbabwe), two national programs (Mozambique and South Africa), and three projects (Ghana, Rwanda and Zimbabwe), which demonstrated that actions to make health services user friendly and appealing had led to increases – sometimes substantial– in the use of health services by adolescents. The quality of care framework provides a useful working definition of adolescent-friendly health services. To be considered adolescent friendly, *health services should be accessible, acceptable, equitable, appropriate and effective.*

Tyylee et al. (2007)[xli] researched on access to primary-health services is seen as an important component of care, including preventive health for young people. Two decades of research in both developed and developing countries have drawn attention to the barriers young people face in accessing health services. growing recognition that young people need services that are sensitive to their unique stage of biological, cognitive, and psychosocial transition into adulthood, and an impression of how health services can be made more youth-friendly has emerged. Recommendations encouraging the removal of these barriers have been complemented by the WHO-led call for the development of youth-friendly services worldwide.

Although adolescents report that they welcome the opportunity to discuss health issues such as contraception, substance use, and sexually transmitted infection with health-care providers and are generally prepared to trust their advice, young people tend not to disclose their health-risk behaviors to health-care providers unless prompted. The paper presented key models of youth-friendly health provision and review the evidence for the effect of such models on young people's health. Though very little evidence was available (at that time), and since many of these initiatives had not been appropriately assessed – but enough was known to recommend that a priority for the future is to ensure that each country, state, and locality has a policy and support to encourage provision of innovative and well assessed youth-friendly services. *GEARY, Rebecca S. et al . (2015)* investigated young people's experiences of using sexual and reproductive health services at clinics providing the YFS program, compared to those that did not, using the simulated client method. [xlii]There was no evidence that clinics providing the YFS program provided a more positive experience to simulated clients, or were more likely to be recommended by simulated clients to their peers, than those not providing this program. Positive and negative experiences were predominantly determined by the healthcare worker's attitudes and behavior. Although the YFS program includes healthcare worker training, these results indicate a need for improvements in healthcare workers' capacity to deliver positive experiences to young people, to address young people's needs for information, contraceptive methods, and testing (for HIV/STIs and pregnancy), and to maintain confidentiality.

Carai et al. (2015)[xliii]did an external review of youth-friendly-health-services in Moldova and the use of the findings to support further planning. While impressive progress with geographical scale up had taken place, services were not always provided to the required quality and comprehensively in the newly established YFHC, thereby diminishing chances of achieving the desired outcomes and impact. Designating health facilities to be made youth friendly and assigning health workers to manage them can be done fairly quickly, improving performance takes time and effort. Approaches that go beyond training such as collaborative learning and job shadowing may hold the best opportunity to improve the knowledge, understanding and motivation of health workers in the newly designated YFHC to address the problem of poor quality. *A.-E. Ambresin et al. 2013*[xliv] in a literature review (22 studies) on young people's perspectives on health care with a view to defining domains and indicators of youth-friendly care. Eight domains stood out as central to young people's positive experience of care. These were: accessibility of health care; staff attitude; communication; medical competency; guideline-driven care; age appropriate environments; youth involvement in health care; and health outcomes. Staff attitudes, which included notions of respect and friendliness, appeared universally applicable, whereas other domains, such as an appropriate environment including cleanliness, were more specific to particular contexts. Measures of youth-friendly health care should address universally applicable indicators of youth-friendly care and may benefit from additional questions that are specific to the local health setting. Four constructs (satisfaction with care, experience of care, quality of care, and patient-centered care) were identified. Across and within different countries, adolescent health needs and issues will be highly heterogeneous, reflecting different economic, sociocultural and developmental contexts. Analysis of studies from very different cultural and clinical settings suggests that young people's appreciation of adolescent friendliness reflects a hierarchy of needs. However, some domains and indicators appeared universally applicable. For example, foremost in every study were indicators of patient centered care. Feeling respected by the health care provider was one such

example that was closely related to trust and friendliness of medical staff and the importance given to continuity of care. These apparently universal domains and indicators appear to constitute the base of a hierarchy of indicators. Context-specific indicators of youth-friendly care varied according to the setting.

Summary domains of adolescent-friendly care, with examples of relevant indicators 1. Accessibility of health care: location, affordability 2. Staff attitude: respectful, supportive, honest, trustworthy, friendly 3. Communication: clarity and provision of information, active listening, tone of communication 4. Medical competency: technical skills (procedures) 5. Guideline-driven care: confidentiality, autonomy, transition to adult health care services, comprehensive care 6. Age-appropriate environment: Flexibility of appointment times, separate physical space, teen-oriented health information, clean, waiting time, continuity of care, privacy 7. Involvement in health care 8. Health outcomes: pain management, quality of life.

Rutgers International (2016)[xlv] (which has been a major actor in designing, providing and lobbying for CSE and YFHS for adolescents), has been implementing YFHS in partnership with local actors in multiple countries in Africa and Asia. At the center of such interventions is this questions: *Do young people more easily access SRH services with an integrated youth corner, a youth oriented center or regular clinics without special provisions for youth?* Their programs answer some of these questions. For example, Family Health Options Kenya (FHOK) provides all three types of health care and investigated factors that enhance or inhibit youth's access to these services. Remarkably, youth friendly services do not automatically attract youth. Most young people know at least one facility in their neighborhood where they could get SRH information and services. Depending on their needs, youth tend to have slight preferences for one or the other. Youth visit youth facilities, whether integrated or not, most often for SRH information followed by visits for counselling and testing (VCT) services. Youth-only centers are marginally preferred for post abortion care. And married youth are more likely to visit regular health care facilities for family planning and other services, since they do not face stigma. Factors inhibiting service use Privacy is especially a concern in services that are not youth only. Other factors that negatively affect young people's ability to use SRH services in regular clinics include (high) costs, drug stock-outs, opening hours during school or work hours, inadequate staffing leading to long queues and waiting times. Youth also experienced drug stock-outs or supply delays in stand-alone facilities. Younger service seekers have more difficulties accessing SRH services of all types because of the common perception of parents, the community and the youths themselves, that they don't need information or services.

More program evidences from countries like Kenya and Zimbabwe, (Erulkar et al. 2005)[xlvi] show that adolescents rated confidentiality, short waiting time, low cost and friendly staff as the most important characteristics of YFHS. The least important characteristics included youth-only service, youth involvement and young staff, suggesting that adolescents do not prioritize stand-alone youth services such as youth centers, or necessarily need arrangements particular to youth such as youth involvement. The findings imply that most existing clinical services, even in the most resource-poor settings, are in a position to improve their level of youth friendliness. This analysis revealed that many aspects of youth-friendliness are not as important to adolescents as commonly thought. Youth-only facilities, a hallmark of youth centers, do n highly in the service preferences of adolescents, yet considerable investment has gone into this model. Similarly, the involvement of peer educators or the involvement of youth in running programs does not

seem to be as high a priority as is commonly thought. What does seem to be important are service aspects that are important to adult clients also. Long waiting time, long distance to clinics, inadequate provider-client interactions, and insufficient time spent for consultation as problematic. These findings imply that in many developing country settings, existing facilities can be upgraded with minimal monetary investments to meet the RH service preferences of adolescents and make them youth- friendly. Such strategy is probably more feasible than establishing new, and often expensive, standalone services for adolescents, such as youth centers. Community support for adolescent RH was a more important predictor of young people seeking RH services than was the quality of service. *MMARI, AND MAGNANI (2003)*[xlvii], in similar study in Zambia indicate that although the projects appear to have improved the clinic experience for adolescent clients and to have increased service use levels at some clinics, the findings suggest that community acceptance of reproductive health services for youth may have a larger impact on the health-seeking behaviors of adolescents.

More evidences like in Mazur, Decker, Brindis, 2016[xlviii], a review that identified 20 studies from an initial search of more than 12,000 records, including six from high-income countries and 14 from low-and-middle-income countries identified 119 indicators used for measuring youth-friendly sexual and reproductive health services. The three most frequently assessed domains were accessibility, staff characteristics and competency, and confidentiality and privacy. The majority of the indicators were not specific to youth needs and often reflected basic standards of care. Our review showed no consistency in the tools or indicators used to measure youth-friendliness. This review shows the need for standardization and prioritization of indicators for the evaluation of YFHS. The results can be used to identify a core set of indicators that can be incorporated into a framework for assessing youth-friendly sexual and reproductive health services. There is a need to further distinguish between those variables that may have greatest impact on the use of services by adolescents, such as respect and privacy, those that impact the quality of services offered, and those that have limited relevance. More rigorous studies using a standardized and prioritized set of indicators is critical to measure the impact and effectiveness of YFHS efforts. *Reif et al. (2016)*[xlix]analyzed a comparative study on outcomes among HIV-positive adolescents before and after implementation of an adolescent HIV clinic in Port-au-Prince, Haiti. Implementation of a youth-friendly adolescent clinic improved retention in HIV care among adolescents, particularly in the assessment of ART eligibility and ART initiation. Additional interventions are needed to improve retention among pre-ART patients and support long-term retention among ART patients. Our results emphasize that implementation of youth-friendly HIV services can improve outcomes, particularly in the first six months after HIV testing; however, pre-ART attrition remains extremely high and more work is needed to engage asymptomatic patients and promptly initiate ART-eligible patients on treatment. The finding that youth-friendly clinic services did not impact long-term retention of ART patients underscores the multiplicity of socio-economic, family and community factors, which acutely influence adolescent behavior in addition to clinic-level factors. Interestingly, the adolescent clinic improved retention in the early cascade steps when clinical services are the focus, i.e.one-stop solution. The dedicated space also may have reduced stigma and increased confidentiality given that patients no longer mix with adults. Finally, training staff in youth-friendly care may have increased acceptability of services. However, long-term retention (both pre-ART and ART), which is highly influenced by social factors such as stigma, isolation and lack of psychosocial support,

and economic factors such as access to transport fees and food remain challenges that are not easily influenced by clinic-based interventions. These social, behavioral and structural barriers are exacerbated by the emotional, psychological and physical changes that occur during adolescence, creating a "perfect storm," which impedes long-term retention. Additional interventions beyond clinic-based services are needed to address long-term retention. Interventions may target social and behavioral barriers, facilitate family disclosure and encourage family support. Studies suggest strengthening adolescents' social networks improves retention by reducing isolation and HIV-related stigma, and improving family relations, and providing services in community-based programs outside of the clinic could reduce the stigma of attending an HIV clinic and alleviate transportation costs.

Brittain et al 2015[l] show that "Youth-friendly" family planning services, services tailored to meet the particular sexual and reproductive health needs of young people (aged 10–24 years), may improve reproductive health outcomes, including reduction of unintended pregnancy. This review demonstrates that there is limited evidence that youth-friendly services may improve reproductive health outcomes for young people and identifies service characteristics that might increase their receptivity to using these services. Although more rigorous studies are needed, the interventions and characteristics identified in this review should be considered in the development and evaluation of youth-friendly family planning interventions in clinical settings. In the context of apparently resource rich country, like in Sweden, M. Hällström et al. 2016[li] show how even though Adolescent health services, or youth centers, have been established throughout Sweden with the ambition to exclusively address issues in relation to adolescent health - an adolescent health service in Angered, a district in a large Swedish city facing a combination of challenges and resources on account of high prevalence of different nationalities as well as socio-economic disadvantage, high-risk lifestyles and high rates of ill-health. This evaluation of an adolescent health service in a district in a large Swedish city illustrates that, in order to be attainable, comfortable and encouraging for young people, such services would benefit from enhancing qualities such as competence, concern and respect amongst staff; ensuring acceptable practical arrangements; and tailoring efforts to disseminate information about and familiarization with the services to both adolescents and parents. By providing accessible and acceptable health care for young people in an otherwise eventful and sometimes unstable period of age, adolescent health services can contribute to fulfilment of young peoples' equal right to health and well-being. In order to adapt such services to the needs of target populations and thereby facilitating access to and visits as such services, we argue that three aspects are particularly potent: information, familiarization and participation, and practical arrangements.

In Latin America, GOICOLEA et al. (2016)[lii] investigated the process through which four clinics in two countries – Peru and Ecuador – introduced, developed and sustained AFHSs. The findings showed that the process of introducing, developing and sustaining AFHSs was long term, and required a creative team effort and collaboration between donors, public institutions and health providers. The motivation and external support was crucial to initiating and sustaining the implementation of AFHSs. Health facilities' transformation into AFHSs was linked to the broader organization of country health systems, and the evolution of national adolescent health policies. In Peru, the centralized approach to AFHSs introduction facilitated the dissemination of a comprehensive national model to health facilities, but dependency on

national directives made it more difficult to systemize them when ideological and organizational changes occurred. In Ecuador, a less centralized approach to introducing AFHSs made for easier integration of the AFHSs model.

Chandra-Mouli et al. (2016)[liii] took on the state actor in SRHR and YFHS and asked: *Do efforts to standardize, assess and improve the quality of health service provision to adolescents by government-run health services in low and middle income countries, lead to improvements in service-quality and service-utilization by adolescents?* Their analysis of eight LMIC from different parts of the world shows that the governments of these countries have set clear expectations for the quality of health service provision to adolescents at the primary care level. In the analysis of the quality of health service provision in these countries showed measurable improvements, although these were uneven. Regarding health facility-based service statistics and community-based coverage studies shows that improvements in the quality of health service provision are accompanied by improvements in service utilization by adolescents. The results clearly show that the quality of health service provision to adolescents in government-run health facilities and their utilization can be improved in different social, economic and cultural contexts. The study found out that improvement of the quality of health service provision to adolescents by government run facilities in LMIC can be possible (example, Tanzania, India and Ukraine) even within the context of routine program – contrary to many previous suggestions that such improvements can only be brought about through well-funded and tightly managed projects.

SECTION 2: INTERLINKAGES AND GAPS BETWEEN CSE AND YFHS

Findings: Interlinkages and Gaps

i. Knowledge, information, Intentions: The basis of both CSE and YFHS is the principle that young people have the right to knowledge about their bodies, sexualities, safety, risks, solutions etc. The body and its wellbeing is at the center of both programs, and each compliments the other in encouraging through correct information and motivation to inculcate respect, confidence and care for the self. The skills are learnt in CSE programs often bring young people to YFHS centers to seek assistance and support. Both work in hard negotiation with social norms and (non)acceptance of young peoples' sexuality: the battle for both programs begin with social norms and cultures in most cases, which are unwilling to accept or even define adolescent and young people as sexual beings. The fear of triggering sexual activities and fear of promiscuity amongst young people (outside marriage) – is something that any sex education curriculum and youth center must debate against. The advocacy for positive messages regarding adolescent and young peoples' wellbeing, and SRHR being an integral part of it – is the foremost common link between CSE and YFHS. Finding allies and support from stakeholders within the community to educate this target group through curriculum based lessons and providing related services is a common challenge, and it is something that multiple implementation partners have been working on in most cases.

ii. Finding common language, texts and materials of SRHR: a big part of effectiveness for any adolescent SRHR program is to find the 'correct' language and vocabulary for sexuality and reproductive issues suitable

for the specific given context. Language around these issues can be taboo, problematic and can cause more stirring than the actual program itself. In many contexts, alliances on SRHR work commonly to build this language and vocabulary to work around otherwise-highly-eroticized-language-of-sex. Using common texts and materials for adolescents in both CSE in schools and YFHS centers helps to communicate strong message and avoids confusions. Having larger alliances, and having all partners use the same texts and materials in a synthesized manner reduce the reoccurring costs and make for effective programs.

iii. Innovations in Complementary services to each other: while CSE can provide basic information on SRHR, it still is limited by its own scope within the school system, which barely provides for counseling or support system that a student might need. Having YFHS center nearby or some operational aspect of it present within the school premises – young people are offered better access to some kind of service that are suitable for them. Also, peer educators and role models are sometimes used to link between school based CSE program and YFHS in the locality.

iv. Involvement of adolescent and young people in program design, monitoring and action research/evaluation: increasingly, CSE and YFHS programs are involving adolescents and young people in the processes of designing/reviewing curriculum, in continuous monitoring systems and evaluation of programs. YFHS also offer opportunities for older adolescents (who have had CSE as their primary entry to the knowledge of ASRHR) to be involved in providing service or doing active advocacy for YFHS. Using trained young people and transferring their skills from CSE to YFHS is an important link.

Gaps in knowledge translation to knowledge use

1. Attitudes of CSE: CSE, even with its best intentions and global endorsements, still face resistance and challenges from local contexts mainly because of the 'sexual' component of it. One of the reasons might be that within development sector, when new 'modern' programs like CSE are brought about, it is often accompanied with an attitude of benevolence and improvement (of the existing backward belief system). For local actors, it can feel imposed and an un-intentional process of 'othering' can occur. CSE is discussed in a manner as if CSE is happening in a vacuum. Attitudes and approaches to CSE , or even YHFS should be brought in with a more grounded and humble attitude that recognizes historical and worldwide debates and negotiations with cultures, religions and politics – and then try to advocate for the merits of having a comprehensive sex education, which is much more than pure sex or sexuality.

2. Approaches – bring gender-power-rights back at the center of discussion: The emphasis in recent times, through evidences from various reviews around the world, is that we need to combine a 'gender-power-rights' framework for CSE and YFHS. This is, probably, one of the most promising inter-linkages between CSE and YFHS – to bring gender back at the center of discussion. Gender, firstly, is already a common and popular currency in development and has a relatively more settled history with target audiences. Taking social systems, their complexities and how members, such as adolescent and young ones, can benefit from being aware of themselves (through their gender roles, responsibilities and dynamics) including bodies and relationship – can become useful for both programs. It has been understood by all development actors,

including the governments that at the heart of ASRHR is gender equality or lack of it in the existing social system. Gender discrimination, especially against girls, is the root cause to child marriage, early pregnancy, maternal health/mortality, GBV/VAW, drop out from secondary education and less participation in labor market by girls. Therefore, addressing gender inequality in terms of beliefs, attitudes, and norms and promotion of more equitable power relations will contribute in improving sexual and reproductive health of adolescents, will result in positive change in behavior and practices. Interventions, therefore, have to promote gender-equitable norms and power relationships as well as human rights as basic framework for ASRHR.

3. Eliminating protectionist and underlying moralistic agenda of CSE and YFHS: even when we are trying to implement CSE and provide inclusive, progressive agenda – the content and delivery is still dominated by traditional approach of sex education - which is teaching sexual morality and propriety, and fear tactic to prevent teen pregnancy and STI/HIV. Even within CSE, and its various versions/interpretations, there is always a 'hidden curriculum' of establishing heteronormativity. Also CSE is very 'protectionist' in its discourse, and has inherent gender biases, asexual in delivery of information. CSE alone cannot promote and fight against these biases and limitations and YFHS as a complimentary/support program, in line with similar messages and consultations can help deconstruct heteronormativity, gender biases hierarchical power relations for young people.

4. Knowledge Gap*:* researchers (Darroch ET AL. 2016), identified three major gaps: a) *coverage gaps*: information is not uniformly available for all adolescents worldwide. Excluded groups of adolescents in developing regions (like Unmarried/never-married women; Adolescents younger than 15; Youth in vulnerable situations; Male adolescents etc.) ; b) *Underreporting gaps*: Sexual and reproductive behaviors are generally self-reported, and are therefore subject to underreporting. This is especially true for stigmatized or illegal behaviors; c) *Substantive gaps*: Social, cultural and economic factors, and the interplay among them, which influence adolescents' sexual and reproductive behaviors, and they can also mitigate or worsen the impacts of these behaviors. There is a dearth of rigorously monitored and evaluated, and finally properly documented knowledge base from which other new programs and initiatives can learn. More and more research as well educational institutes at both national and international level are to be involved in these processes. A systematic and coordinated effort to create knowledge pool can contribute in developing and testing interventions to improve ASRHR. This evidence based knowledge will help us adopt or scale up interventions and projects to scale without compromising their quality.

5. Hard to Reach groups: CSE is mainly delivered through school based curriculum oriented programs, which allows it to reach out to a large number of adolescent and young people as most countries are committed to ensure education for all policies. But the reality is that, many developing countries face high school-drop out rates, especially girls dropping out at the onset of puberty, children reaching schools at a later age (for example, in non-formal primary education)and young people in conflict areas or victims of forced migrations, refugees – will not be reached out through school based CSE programs. Out of these hard-to-reach groups, a large number are likely to be under 15 years old (and in case of girls, a majority will be

married and not return to schools). Age-fixed content do not adequately allow for these diversities in hard to reach groups. What cannot be achieved through school based CSE models, can be complimented through YFHS programs that share common texts, materials and services to educate and impart knowledge on SRHR.

6. The dominant perceptions of heteronormativity and normalcy versus inclusiveness: one of the biggest challenges of SRHR for adolescent and young people in many countries is inclusiveness and advocating sexual diversity as part of its rights-framework. But most countries around the world do not recognize sexual diversity as part of citizen's rights and have legal system in place to block these. In the current situations of the rise of many radical religious elements, lives should be more valued than programs. Risking vulnerable youth from diverse identities and communities – is the last thing that CSE and YFHS programs should want. If diversity cannot be included in formal CSE curriculum, then a provision of confidential counseling in YFHS can provide some kind of space for young people to talk or deal with these issues. In contexts as complex as the current ones, programs need to find new strategies and inter-linkages to accommodate risky issues in innovative ways. Interesting research and analytical work on sex education and curriculum indicate that even though CSE appear to be positive, inclusive and operates within this notion of freedom-agency-choices for learners - it still ignores or marginalizes problematic issues like ambivalent sentiments, confusion, negativity, failures, non-recognition etc.

6. Mental Health Gap: It is estimated that 10-2-% of young people suffer from mental health related issues, and experts see schools as one of the most important community settings for promoting the mental health of young people. Interventions which combine psycho social wellbeing with reproductive and sexual health education and physical health and fitness can have a significant positive effect on pupils' risk-taking and pro-social behavior. The present different service models including YFHS attempt to address these issues, in a rather limited way. The key challenges to addressing mental-health needs of adolescent and young people as: shortage of mental-health professionals, the fairly low capacity and motivation of non-specialist health workers to provide quality mental-health services to young people, and the stigma associated with mental disorder. A population-based, youth focused model, explicitly integrating mental health with other youth health and welfare expertise is suggested by experts.

7. New content to fit the new life situations of young people: Interventions like CSE and YFHS are not yet targeting the increasing number of children and young people who are refugees, living in conflicts and remain uprooted for other reasons – and when they do, these programs need to be redesigned to as their life situations and experiences of body, sexuality, health and overall well-being is far from our perceived and dominant notions of happy-sanitized-peaceful courses of life. Researches show that reaching the most vulnerable still remains the major challenge for CSE and YFHS efforts around the world.

8. Involving parents and gatekeepers as powerful agents of change in CSE and YFHS: Reviews suggest that involving parents and communities have long term impact of effective SRHR for adolescents. Reviews also indicate that peer-educators are not as effective as one imagines it to be. In most cultures, the power of individual agency is still relational, i.e. depends on the membership privileges. Support, love, protection

and acknowledgement from parents make young people confident about their sense of entitlement, rights and agency. Involving parents in CSE activities (both in school and at home), and using them as advocates for encouraging young people to seek services from YFHS can play crucial role in long term success of the programs. Programs and interventions should be community based and the adolescents' immediate social surrounding oriented.

9. Problem with Scaling up and interlinkage/integration with cross-sector programs and make Government as an Ally: Government (GOB) remains at the center of development. It is only through partnership with GOB initiatives, we can ensure adolescent friendly services, stationed within government's Adolescent friendly health centers, or national curriculum, teacher training and media campaigns. One of the major barriers for effective ASRHR is lack of real commitment of governments on the one hand and lack of delivery capacity – technical and financial – on the other. In order to reach out the vast population of adolescent and young people, scaling up of CSE and YFHS - collaboration with government actors, in a multi sector approach is the best chance.

10. Articulation of Wider Outcomes: since most policies and content of CSE and YFHS are very focused on specific issues like reducing risky behavior, or maternal mortality, HIV, child marriage or specific outcomes - the success and retention rate of SRHR knowledge, behavior and service seeking pattern is still relatively low and limited to targeted agenda. Most programs demonstrate success in one or two specific behavior change or knowledge base. Therefore, questions are increasingly being asked as whether we should have or aim at a wider range of 'outcomes' or not - other than majorly focusing on disease and risky behaviors. Evidences suggest that efforts to address underlying social issues may pay off multiple interrelated outcomes.

Section 3: New opportunities – Research and Questions

More research on new approaches*:* Lack of evidence through rigorous research, is not only limited to CSE, but it includes YFHS as well. One of the most important areas of research needed badly, is on the practical experiences on effective ways of programs providing adolescent and young people with information and services. More information and evidences is needed on intervention delivery mechanisms. It is seen that many of the programs and projects aiming to improve ASRHR were often small in scale and short lived; generally poorly monitored, evaluated, and documented. International NGOs and universities carried out a number of research studies and evaluations, but only a small proportion of these were aimed at developing and testing interventions to improve ASRHR. Researchers should determine more rigorously which mediating factors have the greatest impact on behavior in different cultures and which educational strategies and activities are more effective in changing these factors both across and within cultures. Also more rigorous studies on the promising programs need to be conducted and negative results should be encouraged to be published by researchers for better learning purposes.

Capacity building and budgetary consideration for research: Lack of systematic and sufficient number of researches to generate evidences; as well as a rigorous evaluation of programs and projects, especially

those ones with multi-component and multi-level objectives/operations – are areas that need more vigorous attention. But most programs do not include such rigorous and thorough processes of research in their plans because of three main reasons: 1. Time bound nature of projects: because most projects are small scale and short duration – projects cannot fit in proper research activities in them; 2. Lack of capacity: and 3. Budget: most projects within SRHr have very limited finances, and overhead costs take away a major share of these budgets. To balance budgetary tight rope walk to reach project activity goals and to generate evidence – is a difficult one. Therefore, along with capacity building of researchers, it is an absolute necessity to invest more into ASRH and to encourage more innovative programs in this area of work.

Sustainable Development Goals (SDGs), especially Goal 3, 4, 5, with some specific targets – bring new opportunities for CSE and YFHS to work in an interlinked manner and be more far reaching and effective.

GOAL 3: Ensure healthy lives and promote well-being for all at all ages; and the its target 3.7 (By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs) ; Goal 4: Ensure inclusive and quality education for all and promote lifelong learning (targeting full enrollment of all children to schools and guaranteeing quality education for all); Goal 5: Achieve gender equality and empower all women and girls (which targets to eliminate all kinds of gender inequality, GBV, empowerment and rights) – are combination of CSE and YFHS principles, visions and delivery methods. In order to reach out to maximum number of adolescents (especially the under 15 category), forces need to combine efforts in:

1. Increasing funding for SRHR;
2. Reaching out to the national coalitions;
3. Increase regional collaboration and sharing of capacity and resources;
4. Effective mechanisms for accountability-monitoring-advocacy;
5. CSE should be formally incorporated in Goal 4, as part of inclusive and quality education, and should promote gender-focused curriculum;
6. Mental health (target 3.4) should be incorporated with target 3.7 and be part of Goal 4 (curriculum for wellbeing), and more specifically it must be feature in Goal 5 as inequality, violence and discrimination based on gender challenge psycho-social wellbeing of young girls and women.
7. YFHS, as an cross sectoral program, be advocated as a hub for all these goals and targets: it should be designed and promoted as a safe space where adolescent and young people can come for education of sexual and reproductive matters, know about gender rights as well as SR rights; and can avail services that are needed. Ideally YFHS should appeal to different programs that otherwise work in silos to achieve development goals in general, but can achieve much more in a synchronized manner.

What research questions still exist?

- Youth centers and peer education are indicated to be ineffective in changing ASRHR (Chandra-Mouli et al., 2015): how do we re-design collaborative programs between CSE and YFHS involving communities that can ensure cost effective and multi-outcome based ASRHR?
- Can private sector investment and engagement in providing YFHS be an option at a time when funding in SRHR lives under the constant threat being diminished?
- How can CSE be designed to reach the hard-to-reach adolescent population, especially in conflict areas?
- Can concentrating on network and capacity building initiatives amongst sexually diverse adolescents be more effective in achieving the inclusive rights-based SRHR for adolescent in the current anti-LGBTQI environment in many countries?
- Mental health as part of ASRHR and wellbeing – more researches need to be engaged with the importance and relevance of psycho social wellbeing of adolescents, and ways in which CSE and YFHS can include mental health issues in their programs, individually as well as collaboratively.
- Generating more evidences on content and delivery of CSE – cross country research on these two areas should be made priority (since weak content has been flagged as a concern, Chandra-Mouli et al. 2015).
- More evidences through research is needed to understand whether large alliances and pooled together funds are indeed effective in promoting ASRHR through CSE and YFHS?

Annex 1: 17 Characteristics of SE programs in Kirby et al. (2006: 213)

The Process of Developing the Curriculum	The Contents of the Curriculum Itself	The Implementation of the Curriculum
1. Involved multiple people with different backgrounds in theory, research and sex/HIV education to develop the curriculum	***Curriculum Goals and Objectives***	1. Secured at least minimal support from appropriate authorities such as ministries of health, school districts or community organizations
2. Assessed relevant needs and assets of target group	1. Focused on clear health goals – the prevention of STD/HIV and/or pregnancy	2. Selected educators with desired characteristics (whenever possible), trained them and provided monitoring, supervision and support
3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors	2. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them	3. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement, e.g., publicized the program, offered food, or obtained consent
4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, and supplies)	3. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behaviors (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy)	4. Implemented virtually all activities with reasonable fidelity
5. Pilot-tested the program	***Activities and Teaching Methodologies***	
	4. Created a safe social environment for youth to participate	
	5. Included multiple activities to change each of the targeted risk and protective factors	
	6. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors	
	7. Employed activities, instructional methods and behavioral messages that were appropriate to the youths' culture, developmental age, and sexual experience	
	8. Covered topics in a logical sequence	

Annex 2:

UNESCO 2009, Summary of 18 characteristics of effective programs:

Characteristics 1. Involve experts in research on human sexuality, behavior change and related pedagogical theory in the development of curricula. 2. Assess the reproductive health needs and behaviours of young people in order to inform the development of the logic model. 3 Use a logic model approach that specifies the health goals, the types of behavior affecting those goals, the risk and protective factors affecting those types of behavior, and activities to change those risk and protective factors. 4. Design activities that are sensitive to community values and consistent with available resources (e.g. staff time, staff skills, facility space and supplies). 5. Pilot-test the program and obtain on-going feedback from the learners about how the program is meeting their needs. 6. Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy. 7. Focus narrowly on specific risky sexual and protective behaviors leading directly to these health goals. 8. Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them. 9. Give clear messages about behaviors to reduce risk

of STIs or pregnancy. 10. Focus on specific risk and protective factors that affect particular sexual behaviors and that are amenable to change by the curriculum-based program (e.g. knowledge, values, social norms, attitudes and skills). 11. Employ participatory teaching methods that actively involve students and help them internalize and integrate information. 12. Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors. 13. Provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection. 14. Address perceptions of risk (especially susceptibility). 15. Address personal values and perceptions of family and peer norms about engaging in sexual activity and/or having multiple partners. 16. Address individual attitudes and peer norms toward condoms and contraception. 17. Address both skills and self-efficacy to use those skills. 18. Cover topics in a logical sequence.

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