Guidance for a monitoring and evaluation framework for school-based Family Life Education

in Fiji, Kiribati, Samoa, Solomon Islands, Tonga and Vanuatu

Prepared by the Burnet Institute for
UNFPA Pacific Sub-Regional Office

Supported by the
Australian Government

November 2020

Australian Aid

Burnet Institute
Medical Research. Practical Action.

Acknowledgements

This guidance for a monitoring and evaluation framework for school based family life education (FLE) was commissioned by the United Nations Population Fund (UNFPA) and undertaken by the Burnet Institute under the Australian Government funded *Transformative Agenda for Women, Adolescents and Youth in the Pacific* programme. The content in this guidance is presented and shared as a basis for future collaborative discussion and adaptation with Ministries of Education representatives and other national stakeholders, to support the development of locally contextualised national monitoring and evaluation frameworks for FLE for the six programme countries.

This guidance was prepared by Liz Comrie-Thomson of the Burnet Institute on the lands of the Boon Wurrung and Wurundjeri peoples of the Kulin nation. We hereby acknowledge the contribution and inputs provided by Brian Kironde, Jaya Jaya and Kathleen Taylor from UNFPA, Katherine Hampton and Nate Henderson from FPNSW and independent consultant Kristen Joiner.

Recommended citation:

United Nations Population Fund, Burnet Institute (Liz Comrie-Thomson). *Guidance for a monitoring and evaluation framework for school based Family Life Education in the Pacific(2020).*

Table of contents

Acronyms

ATDV	Acceptance of Teen Dating Violence
AWSA-GE	Attitudes towards Women Scale for Adolescents – Gender Equality subscale
CCTST	California Critical Thinking Skills Test
EMIS	Education Management Information System
FLE	Family life education
GSE	General Self-Efficacy scale
GSWCAH	Global Strategy for Women's, Children's and Adolescent's Health (2016-2030)
HIMF	Healthy Islands Monitoring Framework
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
ICPD Beyond 2014	International Conference on Population and Development Beyond 2014
ISA	Ambivalent Sexism Inventory for Adolescents
ITGSE	International Technical Guidance on Sexuality Education
MEF	Monitoring and evaluation framework
MOE	Ministry of Education (or Ministry with responsibility for education)
PEP	Post-exposure prophylaxis
PPAV	Perceived Peer Acceptance of Violence
PSRO	Pacific Sub-Regional Office of UNFPA
SDGs	Sustainable Development Goals
SDP	Service delivery point
SERAT	Sexuality Education Review and Assessment Tool
SRESAYA	Sexual and Reproductive Empowerment Scale for Adolescents and Young Adults
SRHR	Sexual and reproductive health and rights
SRPS-RC	Sexual Relationship Power Scale – Relationship Control sub-scale
STI	Sexually transmitted infection
TA	A Transformative Agenda for Women, Adolescents and Youth in the Pacific: Towards Zero Unmet Need for Family Planning 2018-2022
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

Family life education (FLE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality and family formation. A well designed and implemented FLE program can prepare children and young people for healthy and responsible relationships throughout their lives. FLE also supports young people to develop good health, and safeguard their own and others' sexual and reproductive health and rights.

There is increased attention and investment in FLE from national governments globally and in the Pacific region. Embedding a comprehensive monitoring and evaluation framework in a national FLE program supports the program to achieve maximum impact by tracking implementation quality and school-level outcomes, and assists policymakers and school leaders to tailor the program to evolving population health needs and other national priorities.

The seminal assessment framework for school-based FLE is UNESCO's Sexuality Education Review and Assessment Tool (SERAT), which was updated in 2020 to align with current UNESCO guidance on effective FLE programs included in the 2018 revision of ITGSE. SERAT is designed for intermittent, retrospective evaluations. The purpose of this document is to guide countries in continuous monitoring and evaluation of school-based FLE.

As a first step in developing a monitoring and evaluation framework, a theory of change for school-based FLE was prepared based on a UNFPA logic model for FLE programs, supplemented by the logic framework that underpins SERAT. Each concept in the theory of change was then mapped against established indicator frameworks. Wherever possible, indicators were selected from those recommended in SERAT. Where no relevant indicators were included in SERAT, indicators from other globally recognised measurement frameworks such as the Sustainable Development Goals were selected. Indicators to measure changes in student knowledge, attitudes and practices were selected from validated scales to ensure that data can be monitored reliably over time and across locations.

The monitoring and evaluation framework in this guidance is evidence-based and theory-informed, but is not adapted to any particular national context. In order to support continuous monitoring and evaluation of a national FLE program, further adaptation and contextualisation of the program theory of change, indicators, measures of success, and data sources is required.

The framework outlines five data collection mechanisms to capture implementation quality and fidelity, student outcomes (at school level) attributable to FLE, and population-level outcomes that indicate priority areas for FLE. These mechanisms are: checklists to be completed by curriculum development officers when curriculum modules are submitted for ministry or department approval; procedures for student referral to health and social services, to be submitted annually by school leaders; brief knowledge, attitude and practice (KAP) surveys integrated with FLE teaching materials; existing data capture in the Health Management Information System (HMIS), Education Management Information System (EMIS), and annual school reports; and data from routine population-based surveys (e.g. demographic and health surveys or multiple indicator cluster surveys).

Introduction

An evidence-based rationale for family life education

Family Life Education (FLE) is increasingly recognised by countries across the Pacific as an integral component of young people's schooling. Formal education is a critical avenue for promoting young people's holistic wellbeing, including their health, developing sexuality, and future family formation. A well designed and implemented FLE program can prepare children and young people for healthy and responsible relationships at different stages of their lives.[1]

FLE is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality and family formation. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to:[1]

- Realise their health, well-being and dignity;
- Develop respectful social and intimate relationships;
- Consider how their choices affect their own well-being and that of others; and
- Understand and ensure the protection of their rights throughout their lives.

Within the context of FLE, the concept of 'sexuality' typically includes learners' understanding of the human body and reproduction; emotional attachment, love and mutually respectful relationships; gender, gender identity and sexual orientation; and sexual intimacy.[1-3]

A well designed and implemented FLE program supports young people to develop good health, including safeguarding their own and others' sexual and reproductive health and rights (SRHR). This includes developing attitudes and habits that support healthy behaviours and decision-making later in life. FLE can assist young people to maintain their wellbeing, and the wellbeing of their families, as they manage a range of challenges that some of them will inevitably encounter during their youth and across their lives. These include pregnancy and unsafe abortion (particularly in settings with high rates of adolescent pregnancy), access to modern contraception when needed, violence (including sexual violence), HIV and sexually transmitted infections (STIs), explicit media, cyberbullying and sexting, poor emotional and mental health, and use of alcohol, tobacco and other drugs.[1] FLE also provides an opportunity for young people to reflect on their values and rights, and what they want in future relationships and future family life. This empowers learners to form respectful, emotionally rewarding social and intimate relationships that are a critical part of individual wellbeing and social cohesion.

Principles and elements of an effective FLE program

There is a substantial body of evidence for the core attributes of successful FLE programs, comprehensively summarised in the *International Technical Guidance on Sexuality Education* (ITGSE), most recently revised in 2018.[1] These programs support young people to understand, respect, and safeguard their own sexual and reproductive health **rights**, and the rights of others. Successful programs also support students to understand and value **gender equality**, for example by challenging gender norms supportive of male dominance and female passivity that contribute to sexual violence. Programs deliver content that is **delivered throughout students' education** in ways that are **age- and developmentally-appropriate**, for example by supporting young children to demonstrate verbal and non-verbal ways to say yes or no, and assisting older adolescents to communicate personal needs and limits, including around sexual behaviour. Successful programs are **broad** in scope and include content that **may be challenging** for teachers, students, and families. To be most effective, successful programs introduce students to detailed content about sex and sexuality **well before they become sexually active**. Successful programs are supported by a **school environment** that promotes respect for students' rights and gender equality.

Evidence indicates that the following activities are required, at Ministry of Education level and school level, to design and implement effective FLE programs:

Develop a curriculum that includes multiple sessions with sequential content to be delivered over several years, with younger and older students. Reinforce important concepts in age-appropriate and gender sensitive ways over several years, as well as providing young people with clear messages about specific behaviours.[1]

Pilot test the curriculum, and adjust it based on feedback from students and teachers. This helps to ensure content is presented in ways that are comprehensible and acceptable.[1]

1. **During centralised curriculum development and school-level lesson planning, allocate sufficient time to FLE in order to increase its effectiveness.** For example, positive results have been seen in programs that deliver 30 or more sessions per year, with each session lasting approximately 50 minutes.[1]

2. **Employ participatory teaching methods that actively involve children and young people and help them internalize and integrate information.** Ensure participatory methods are matched to appropriate learning objectives.[4-6]

3. **Select capable, motivated educators.** Educators should be able to separate their personal values and attitudes from their professional responsibilities, so that they can interact with students in a non-judgemental way. Educators should be knowledgeable, professional, confident, approachable and unshockable. Educators should be straightforward and use everyday language when talking about sex. Young people report it is very important to them that educators are trustworthy.[7]

4. **Support educators, including through sensitisation, resources to support implementation like teaching aides, flipcharts, posters e.t.c., quality pre-service and in-service training, and continuous professional development opportunities.** School leaders and managers should provide encouragement, guidance and support to teachers involved in delivering FLE. Supervisors need to make sure that the curriculum is being fully implemented as planned, and that teachers have access to support to help them respond to unfamiliar and challenging situations as they arise.[1]

5. **Create a learning environment that supports confidentiality and privacy for all students.** Discussing the topic of sexuality can lead children and young people to feel anxious, embarrassed and vulnerable. Teachers should be well-trained to manage challenging questions and student perspectives. Smaller class sizes and small-group discussions can also support students' sense of safety.[7]

6. **Develop referral and reporting procedures, ensuring these procedures include support for students.** Students who have experienced sexual abuse or coercion, or other types of violence, may decide to disclose this information as they learn more about their rights. When preparing to commence an FLE program, schools should develop procedures to support and refer students who disclose abuse or seek help. These procedures should be in line with local laws and policies, effectively disseminated to teachers and school leaders, and regularly updated to ensure that referral services are appropriate and accessible.[1]

7. **Monitor and evaluate FLE programs throughout design and implementation.** Program scope, content, delivery mechanisms, and impact on student knowledge, attitudes and practices should all be assessed.[1]

Monitoring and evaluating FLE programs

Guidance issued by UNESCO1 and UNFPA[8] outlines three characteristics of monitoring and evaluation approaches that provide information to inform quality, effective FLE programs.

Frequent data inputs from multiple sources and stakeholder groups. There should be regular monitoring and assessment of FLE programs, preferably built into sustainable processes for routine data collection. Number and demographics of students, document review of teaching materials, classroom observations, and interviews or surveys to assess student experiences are recommended.[9] Perspectives of students, educators, schools and communities should be considered.[8] The Sexuality Education Review and Assessment Tool (SERAT)[10] provides a detailed framework and indicators for assessing the delivery and quality of school-based FLE programs.

One or more indicators integrated into national education monitoring systems. Capturing FLE delivery at national level using one or more high-level indicators, likely assessed through annual school reporting, enables systematic assessment of national rollout of FLE programs. This also supports countries to report on Thematic Indicator 4.7.2 of the Sustainable Development Goals (SDGs) which addresses FLE delivery.[11,12] UNESCO recommends the following indicator – which aligns with SDG indicator 4.7.2 – be included by countries within their Education Management Information System (EMIS) as a minimum standard for FLE reporting:[1]

> Did students at your school receive comprehensive life skills-based HIV and sexuality education in the previous academic year?[1]

Detailed information on measurement and assessment of this indicator is available from UNESCO[1] and provided in Appendix 1 of this guidance.

Capture progress through incremental indicators. Indicators should capture incremental progress in both delivery and quality of FLE programs. Sequential indicators should be used to track program implementation, intermediate outcomes and impacts. A program theory of change can be used to clarify the intended process of achieving impact through the FLE program, in order to inform selection of sequential indicators.[8] In addition, indicators should capture incremental progress towards quality standards, in order to document change over time and provide detailed guidance on further changes required.[1]

Aim

The aim of this guidance is to present a sample evidence-based, theory-informed monitoring and evaluation framework for school-based FLE programs in the Pacific. The framework is intended to form a basis for discussion and future adaptation through close consultation with ministry stakeholders and other national representatives, to support ongoing efforts by ministries to strengthen their national FLE programs.

Methodology

As a first step in developing the monitoring and evaluation framework, a theory of change for school-based FLE was prepared. The theory of change was adapted from a logic model presented in UNFPA guidance on the evaluation of FLE programs,[8] supplemented by the logic framework that underpins SERAT.[10] This theory of change is based on global evidence and theory, and is not specific to a country context. It should therefore be adapted for specific countries through close consultation with the Ministry and other national stakeholders prior to use to inform monitoring and evaluation of any specific FLE program.

Each concept in the theory of change was then mapped against established indicators. First, the theory of change was mapped against SERAT version 3.0, which was updated in 2020 to align with current UNESCO guidance on effective FLE programs included in the 2018 revision of ITGSE.[1,10] Wherever possible, indicators were selected from those recommended in SERAT version 3.0. Additionally, a validated scale that measures the quality of implementation of FLE programs, recently developed by Keogh and colleagues through a multi-country study,[13] was included together with SERAT indicators to support a comprehensive assessment of the quality of FLE program outputs. Indicators to capture the short-term outcomes of changes in student knowledge, attitudes and practice are not included in SERAT and were selected from validated scales, to ensure changes can be monitored reliably over time and across locations. For long-term population health outcomes where no relevant indicator is recommended in SERAT, indicators were selected from existing measurement frameworks including the SDGs,[14] the Indicator and Monitoring Framework for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) (GSWCAH),[15] and the Framework of Actions for the Programme of Action of the International Conference on Population and Development Beyond 2014 (ICPD Beyond 2014).[16] There are a small number of process indicators that have been developed specifically for this evaluation matrix because an appropriate indicator was not identified from established measurement frameworks. The source of each indicator is noted in the evaluation matrix.

Results

Sample FLE program theory of change

Program theories of change should not only be evidence-based and theory-informed, but should also respond directly to local context. The theory of change outlined in Figure 1 below is an evidence-based, theory-informed, generic theory of change for school-based FLE, and may be adapted to describe specific FLE programs in close consultation with program stakeholders.

Different types of evaluations are mapped against various stages in the theory of change. Process evaluations assess program implementation in terms of preparatory activities and outputs achieved, as well as assessing what happens in the classroom. Outcome evaluations assess the influence of the program on student knowledge, attitudes and practices relevant to sexual and reproductive health rights. Impact evaluations assess the consequences of these changes in student knowledge, attitudes and practices on broader health and gender equality outcomes.

PROCESS EVALUATION		OUTCOME EVALUATION	IMPACT EVALUATION	
Program activities	**Outputs**	**Short-term outcomes**	**Long-term outcomes**	**Impacts**
P1. Form curriculum development team (or curriculum review team) including female, male and gender-diverse young people **P2.** Outreach with parents, teachers and school leaders, and other community stakeholders during curriculum development process **P3.** Train teachers in use of curriculum, participatory methods, and an approach to sexual and reproductive health that is rights-based and addresses gender and power **P4.** Identify youth-friendly health services (including SRHR services) for referral **P5.** Identify services for victim-survivors and perpetrators of physical, psychological, and sexual violence aged 10-24 years for referral **P6.** Review supply chains for condoms and other modern methods of contraception (including long-acting reversible contraceptives) to ensure they are accessible to young people	**O1.** Parents, principals, students and other school and community stakeholders sensitised, including women and girls, men and boys, and gender-diverse adults and young people **O2.** Final curriculum content addresses all 8 areas recommended by the International Technical Guidance on Sexuality Education (2018) in age- and developmentally-appropriate ways **O3.** Final curriculum content addresses critically reflecting on media messages, including messages shared via social media and explicit media (pornography), in age- and developmentally-appropriate ways **O4.** Final curriculum content addresses digital communication and relationships, in age- and developmentally-appropriate ways **O5.** Teachers from all target schools receive training in curriculum content, participatory methods, and gender power dynamics **O6.** Teachers teach all content and use a rights-based approach **O7.** Teachers use participatory methods to assist learners to engage in critical self-reflection and question established power imbalances **O8.** Lessons are appropriately resourced and supported **O9.** School environment and teachers support a non-discriminatory classroom **O10.** Referral system to accessible, youth-friendly health and social services (including SRHR services, and services for victim-survivors and perpetrators of physical, psychological and/or sexual violence) established for all target schools **O11.** Schools deliver life skills-based HIV and sexuality education	**S1.** Increased student knowledge of reproductive health, including STIs, fertility, pregnancy, and condoms and other modern methods of contraception **S2.** Increased student knowledge of what to do if a person experiences physical, psychological or sexual violence in an intimate relationship **S3.** Increased student self-efficacy to access condoms and other modern methods of contraception **S4.** Increased student self-efficacy to refuse unwanted sex or use condoms **S5.** Improved student critical thinking skills **S6.** Increase in students' gender-equitable attitudes **S7.** Decreased student acceptance of gender-based violence (including physical, psychological and sexual violence)	**L1.** Reduced coercive or controlling intimate relationships among young people aged 10-24 years **L2.** Delayed sexual initiation among young people aged 10-24 years **L3.** Improved care-seeking for SRHR services among young people aged 10-24 years (including HIV/STI testing and treatment, condoms and other modern methods of contraception, support for sexual assault victim-survivors, and post-abortion care) **L4.** Improved care-seeking for physical, sexual and psychological violence among young people aged 10-24 years	**I1.** Improved sexual and reproductive health among young people aged 10-24 years **I2.** More positive, respectful, and gender-equitable relationships between young people aged 10-24 years and throughout the lifecourse

Sample evaluation matrix

In the matrix below, concepts from each stage of the theory of change (Figure 1) are mapped against indicators from established measurement frameworks and validated scales.

This sample evaluation matrix is derived from the sample FLE program theory of change provided above and should be adapted to align with any changes made to the theory of change. Specific indicators and data sources outlined below should also be considered as indicative only, and would need to be adapted to align with existing local data collection mechanisms prior to use. In addition, measures of success would need to be adapted to locally meaningful definitions of success for each indicator, and one or more measures of partial success may need to be defined in order to capture incremental progress from the current situation towards full achievement of specific indicators.

Program activities

Guidance issued by UNESCO[1] based on a comprehensive review of evidence and good practice indicates that the preparatory activities below are integral to the success of effective FLE programs. Indicators have been selected from SERAT[10] and supplemented by indicators on family planning commodities and service provision recommended under ICPD Beyond 2014[16] and the proposed monitoring and evaluation framework (MEF) for the UNFPA-supported program A Transformative Agenda for Women, Adolescents and Youth in the Pacific: Towards Zero Unmet Need for Family Planning 2018-2022 (TA).[17]

PROGRAM ACTIVITIES	Indicator	Indicator source	Measure of success	Data source(s)
P1. Form curriculum development team (or curriculum review team) including female, male and gender-diverse young people	Content development process (or review process) involved consultations with young people, by curriculum module	SERAT[10]	For 100 per cent of newly approved curriculum modules, young people (age 10-24 years) are consulted during curriculum development (or review) and their contributions influence curriculum content	Curriculum checklist
	Content development process (or review process) included female, male, and gender-diverse young people, by curriculum module	-	For 100 per cent of newly approved curriculum modules, female, male and gender-diverse young people (age 10-24 years) are consulted during curriculum development (or review) and their contributions influence curriculum content	Curriculum checklist
P2. Outreach with parents, teachers and school leaders, and other community stakeholders during curriculum development process	Content development process involved consultations with parents/family members, by curriculum module	SERAT[10]	For 100 per cent of newly approved curriculum modules, parents/family members are consulted during curriculum development and their contributions add to curriculum content, by curriculum module	Curriculum checklist
	Content development process involved consultations with teachers and supervisors, by curriculum module	SERAT[10]	For 100 per cent of newly approved curriculum modules, teachers and supervisors (including principals) are consulted during curriculum development and their contributions add to curriculum content, by curriculum module	Curriculum checklist
	Content development process involved consultations with religious groups and traditional leaders, by curriculum module	SERAT[10]	For 100 per cent of newly approved curriculum modules, religious groups and traditional leaders are consulted during curriculum development and their contributions add to curriculum content	Curriculum checklist

PROGRAM ACTIVITIES	Indicator	Indicator source	Measure of success	Data source(s)
P3. Train teachers in use of curriculum, participatory methods, and an approach to sexual and reproductive health that is rights-based and addresses gender and power	Ministry of Education-recognised teacher-training curricula for sexuality education (both pre-service and in-service training) cover the 8 core areas included in the ITGSE, by curriculum module	-	100 per cent of newly approved teacher-training curricula modules (pre-service and in-service) address the 8 core areas as defined in ITGSE: relationships; values, rights, culture and sexuality; understanding gender; violence and staying safe; skills for health and wellbeing; human body and development; sexuality and sexual behaviour; and sexual and reproductive health.	Teacher-training curriculum checklist
	Ministry of Education-recognised teacher-training curricula for sexuality education (both pre-service and in-service training) prepare teachers to effectively deliver participatory learner-centred activities, by curriculum module	SERAT[10]	100 per cent of newly approved teacher-training curricula modules (pre-service and in-service) include content and practical sessions on participatory learner-centred activities	Teacher-training curriculum checklist
P3. (continued) Train teachers in use of curriculum, participatory methods, and an approach to sexual and reproductive health that is rights-based and addresses gender and power	Ministry of Education-recognised teacher-training curricula for sexuality education (both pre-service and in-service training) prepare teachers to apply educational approaches that build students' power to reflect and think critically about their own lives and about the world around them, and to solve problems, by curriculum module	SERAT[10]	100 per cent of newly approved teacher-training curricula modules (pre-service and in-service) include content and practical sessions on supporting learners' critical self-reflection and problem-solving	Teacher-training curriculum checklist
	Ministry of Education-recognised teacher-training curricula for sexuality education (both pre-service and in-service training) include sessions for educators to reflect on the distinction between their own values, biases and opinions, and the actual health needs of learners, by curriculum module	SERAT[10]	100 per cent of newly approved teacher-training curricula modules (pre-service and in-service) include content and practical sessions to support trainee teachers to identify and reflect on their values, biases and opinions, and how these may differ from the health needs of learners	Teacher-training curriculum checklist

PROGRAM ACTIVITIES	Indicator	Indicator source	Measure of success	Data source(s)
P4. Identify youth-friendly health services (including SRHR services) for referral	Percentage of schools with school-based health services where health providers at school-based health services are permitted to offer youth-friendly sexual and reproductive health services	-	100 per cent of school leaders in schools teaching students aged 10 years and older are aware of guidelines that allow school-based health services to offer sexual and reproductive health services (e.g. counselling, VCT, etc.)	Referral SOP
	Percentage of schools with school-based health services where health providers at school-based health services are trained on offering youth-friendly sexual and reproductive health services	SERAT[10]	At 100 per cent of schools teaching students aged 10 years and older with school-based health services, at least one health provider at school-based services has received training or refresher training on offering youth-friendly sexual and reproductive health services within the past 5 years	Referral SOP
	Percentage of schools that have identified a youth-friendly health service that offers SRHR services available to young people (aged 10-24) in the district	-	100 percent of schools teaching students aged 10 years and older have identified one or more locally accessible youth-friendly health services that currently (reviewed within the previous 12 months) provide SRHR services (either school-based or not school-based)	Referral SOP
P5. Identify services for victim-survivors and perpetrators of physical, psychological, and sexual violence aged 10-24 years for referral	Percentage of schools that have identified services for victim-survivors of physical, psychological, and sexual violence available to young people (aged 10-24 years) in the district	-	100 per cent of schools teaching students aged 10 years and older have identified one or more locally accessible services that currently (reviewed within the previous 12 months) provide health and social services for victim-survivors of physical, psychological and sexual violence aged 10-24	Referral SOP
	Percentage of schools that have identified services for perpetrators of physical, psychological, and sexual violence available to young people (aged 10-24 years) in the district	-	100 per cent of schools teaching students aged 10 years and older have identified one or more locally accessible services that currently (reviewed within the previous 12 months) provide health and social services for perpetrators of physical, psychological and sexual violence aged 10-24	Referral SOP
P6. Review supply chains for condoms and other modern methods of contraception (including long-acting reversible contraceptives) to ensure they are accessible to young people	Percentage of facilities reliably offering a range of methods, encompassing 4 categories of contraceptive methods: short-term, long-acting reversible, permanent, and emergency contraception, by district	ICPD Beyond 2014[16]	80 percent of SDPs in each district meet the criteria	HMIS (health facility data)
	Percentage of service delivery points (SDPs) that have at least one member of staff available and fully trained in youth-friendly, disability-inclusive family planning service provision, by district	UNFPA TA[17]	80 percent of SDPs in each district meet the criteria	HMIS (health facility assessments supported under the Transformative Agenda program)

Outputs

Outputs are designed to comprehensively capture implementation quality. They encompass community sensitisation, curriculum content, teacher training, school environment, and referral mechanisms, as well as delivery of FLE lessons in the classroom. Output indicators have been selected from SERAT,[10] supplemented by additional quality metrics recently developed and validated by Keogh and colleagues through a multi-country study[13] that are designed to track the quality of established prerequisites and corequisites for successful implementation of an effective FLE program. SDG indicator 4.7.2, recommended by UNESCO as the minimum reporting standard for delivery of FLE,[1] is also included as an output indicator, with full guidance on measurement and reporting of this indicator provided in Appendix 1.

OUTPUTS	Indicator	Indicator source	Measure of success	Data source(s)
O1. Parents, principals, students and other school and community stakeholders sensitised, including women and girls, men and boys, and gender-diverse adults and young people	Percentage of schools that provided an orientation process for parents or guardians of students regarding life skills-based HIV and sexuality education programmes in schools in the previous academic year	SERAT[10]	100 percent of schools, and for parents/ guardians of students at all year levels	Annual school census
	Percentage of schools that provided training and support for teachers regarding life-skills based HIV and sexuality education programs in schools, including how to respond to opposition or concerns from parents or community members about sexuality education, in the previous academic year	SERAT (adapted)[10]	100 percent of schools, and for teachers at all year levels and all subject areas	Teacher KAP survey (T1)
O2. Final curriculum content addresses all 8 areas recommended by the International Technical Guidance on Sexuality Education (2018) in age- and developmentally-appropriate ways	Curriculum content and participatory activities support learners to develop specified skills, knowledge and attitudes across all 8 ITGSE-recommended areas using messages and activities appropriate to students' ages and developmental stages, by age group (age 5-8 years, age 9-12 years, age 12-15 years, age 15-18 years) The 8 ITGSE-recommended areas are: relationships; values, rights, culture and sexuality; understanding gender; violence and staying safe; skills for health and wellbeing; human body and development; sexuality and sexual behaviour; and sexual and reproductive health.	SERAT[10]	For each approved curriculum module, the checklist indicates where prespecified content (an agreed subset of the content criteria presented in SERAT[1]) is addressed in the curriculum. There are clear messages, and activities, focused on this content. Messages and activities are appropriate to each age group for which FLE is taught.	Curriculum checklist

1 The full list of content criteria presented in SERAT (version 3.0) are included in this document as Appendix 2.

OUTPUTS	Indicator	Indicator source	Measure of success	Data source(s)
O3. Final curriculum content addresses critically reflecting on media messages, including messages shared via social media and explicit media (pornography), in age- and developmentally-appropriate ways	Curriculum content and participatory activities support learners to develop specified skills, knowledge and attitudes using messages and activities appropriate to students' ages and developmental stages, by age group (age 5-8 years, age 9-12 years, age 12-15 years, age 15-18 years)	SERAT[10]	For each approved curriculum module, the checklist indicates where prespecified content (an agreed subset of the content criteria presented in SERAT) is addressed in the curriculum, by age group. There are clear messages, and activities, focused on this content.	Curriculum checklist
O4. Final curriculum content addresses digital communication and relationships, in age- and developmentally-appropriate ways	Curriculum content and participatory activities support learners to develop specified skills, knowledge and attitudes using messages and activities appropriate to students' ages and developmental stages, by age group (age 5-8 years, age 9-12 years, age 12-15 years, age 15-18 years)	SERAT[10]	For each approved curriculum module, the checklist indicates where prespecified content (an agreed subset of the content criteria presented in SERAT) is addressed in the curriculum, by age group. There are clear messages, and activities, focused on this content.	Curriculum checklist
O5. Teachers from all target schools receive training in curriculum content, participatory methods, and gender power dynamics	Percentage of schools with at least 1 teacher trained in the previous 5 years using an approved curriculum that covers the 8 core ITGSE concepts	-	60 percent by 2022 80 percent by 2024 100 percent by 2026	Teacher KAP survey (T1)
	Mean score on Keogh's Teacher Training sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of 20 or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year	Teacher KAP survey (T1)

OUTPUTS	Indicator	Indicator source	Measure of success	Data source(s)
O6. Teachers teach all content and use a rights-based approach	Mean score on Keogh's Comprehensiveness sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of 4.5 or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year	Student KAP survey (T4)
	Mean score on Keogh's Values Imparted sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of 6 or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year	Teacher KAP survey (T1, T4)
	Mean score on Keogh's Monitoring and Evaluation sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of four or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year	Student KAP survey (T4) Teacher KAP survey (T4) Annual school census

OUTPUTS	Indicator	Indicator source	Measure of success	Data source(s)
O7. Teachers use participatory methods to assist learners to engage in critical self-reflection and question established power imbalances	Mean score on Keogh's Teaching Methods sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of five or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year	Teacher KAP survey (T4) Student KAP survey (T4)
	Percentage of schools where teachers regularly engage in participatory classroom teaching (e.g. energizers, discussion triggers, creative play, group discussions, participatory reflection)	SERAT (adapted)[10]	100 percent of schools	Student KAP survey (T4)
O8. Lessons are appropriately resourced and supported	Mean score on Keogh's Resources sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of 2 or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year	Student KAP survey (T4) Teacher KAP survey (resources questions - T1; support questions - T4) Annual school census

OUTPUTS	Indicator	Indicator source	Measure of success	Data source(s)
O9. School environment and teachers support a non-discriminatory classroom	Mean score on Keogh's School Environment sub-scale, by school	Keogh 2020[13]	100 percent of schools achieve a mean score of 5 or above; and Increase in two-year rolling average, by school, for schools with a mean score below the top quintile; and Schools with a mean score in the lowest quintile increase their mean score year-on-year; and Increase in mean scores between Term 1 and end of year surveys, by school and grade	Student KAP survey (T1, T4) Annual school census
	Percentage of schools that have rules and guidelines for staff and students related to physical safety, stigma and discrimination and sexual harassment and abuse that have been communicated to relevant stakeholders	SERAT[10]	100 percent of schools have current guidelines	Annual school census
O10. Referral system to accessible, youth-friendly health and social services (including SRHR services, and services for victim-survivors and perpetrators of physical, psychological and/or sexual violence) established for all target schools	Percentage of schools that report an up-to-date standard operating procedure (SOP) for referral of students to accessible, youth-friendly health and social services (including SRHR services and services for victim-survivors and perpetrators of physical, psychological and/or sexual violence)	-	100% of schools have a referral SOP that has been reviewed within the previous 12 months	Annual school census
	Percentage of schools where teachers are trained in referring students to accessible, youth-friendly health and social services (including SRHR services and services for victim-survivors and perpetrators of physical, psychological and/or sexual violence)	SERAT[10]	In 100 percent of schools, at least 80 percent of teachers have been trained in their school-specific referral SOP in the previous 12 months	Teacher KAP survey (T1, T4)
O11. Schools deliver life skills-based HIV and sexuality education	Percentage of schools that provide life skills-based HIV and sexuality education	SDG 4.7.2[11,12]	100 percent of schools with enrolled students aged 10 years and older	Annual school census
	Percentage of schools that report student and teacher perspectives on implementation of life skills-based HIV and sexuality education	-	100 percent of schools providing life-skills based HIV and sexuality education report student and teacher KAP data at least once per year	Student KAP survey (T1, T4) Teacher KAP survey (T1, T4)

Short-term outcomes

Short-term outcomes are focused on changes in student knowledge, attitudes and practices over the school year. To assess these changes, a pre-test post-test approach is proposed. The pre-test (at the end of the first term of the school year, T1) not only provides a baseline but can also inform teaching strategies for the year, for example through providing insight into students' misconceptions to be addressed and harmful attitudes to be explored through discussion. The post-test (at the end of the school year, T4) captures change over the year at the level of the school grade. The proposed short-term outcome indicators are validated scales, meaning they have undergone rigorous statistical testing to ensure that each scale measures the concept it is intended to measure. Using validated scales enables students' scores (including mean scores) to be compared over time, and between schools. It is recommended that these indicators be captured by school and by year level within school, to directly inform school-level planning and experience-sharing and supportive supervision among teachers.

SHORT-TERM OUTCOMES	Indicator	Indicator source	Measure of success	Data source(s)
S1. Increased student knowledge of reproductive health, including STIs, fertility, pregnancy, and condoms and other modern methods of contraception	Knowledge questions of WHO Illustrative questionnaire for interview-surveys with young people (sections 2, 7-9), by school and year level	Cleland 2001[18]	Increase in mean score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
S2. Increased student knowledge of what to do if a person experiences physical, psychological or sexual violence in an intimate relationship	Adapted sub-scale of General Self-Efficacy scale (GSE), by school and year level	Luszczynska 2005, Schwarzer 2010[19,20]	Increase in sub-scale score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
S3. Increased student self-efficacy to access condoms and other modern methods of contraception	Adapted sub-scale of General Self-Efficacy scale (GSE), by school and year level	Luszczynska 2005, Schwarzer 2010[19,20]	Increase in sub-scale score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
S4. Increased student self-efficacy to refuse unwanted sex or use condoms	Sexual and Reproductive Empowerment Scale for Adolescents and Young Adults (SRESAYA), by school and year level	Upadhyay 2020[21]	Increase in SRESAYA score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
S5. Improved student critical thinking skills	California Critical Thinking Skills Test (CCTST), by school and year level	Facione 1994, Miri 2007[22,23]	Increase in CCTST score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
S6. Increase in students' gender-equitable attitudes	Ambivalent Sexism Inventory for Adolescents (ISA), by school and year level	Ramiro-Sánchez 2018, De Lemus 2008[24,25]	Increase in ISA score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
	Gender Equality subscale of the Attitudes towards Women Scale for Adolescents (AWSA-GE), by school and year level	Jaruseviciene 2014[26]	Increase in AWSA-GE score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
S7. Decreased student acceptance of gender-based violence (including physical, psychological and sexual violence)	Acceptance of Teen Dating Violence (ATDV), by school and year level	Ruel 2020[27]	Decrease in ATDV score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)
	Perceived Peer Acceptance of Violence (PPAV), by school and year level	Bogen 2020[28]	Decrease in PPAV score between Term 1 and Term 4, by school and year level	Student KAP survey (T1, T4)

Long-term outcomes

The long-term outcomes below are intended to capture young people's health behaviours and care-seeking at population level, as well as power relationships within young people's intimate relationships at population level. These outcomes can be measured through population-based surveys and health system data. Although it is not possible to conclusively attribute any changes in population-level outcomes to the impact of a national FLE program, it remains valuable to track the intermediate outcomes that the FLE program aims to address. Data on young people's care-seeking should be interpreted together with data on health service quality.

LONG-TERM OUTCOMES	Indicator	Indicator source	Measure of success	Data source(s)
L1. Reduced coercive or controlling intimate relationships among young people aged 10-24 years	Sexual Relationship Power Scale – Relationship Control sub-scale (SRPS-RC), by sex and age (aged 10-14 years; aged 15-19 years; aged 20-24 years)	Pulerwitz 2000[29]	Increase in SRPS-RC score between survey timepoints by sex and age group	Population-based survey (e.g. DHS, MICS)
L2. Delayed sexual initiation among young people aged 10-24 years	Proportion of young people aged 15-24 who had sexual intercourse before age 15, by sex and age (aged 15-19 years, aged 20-24 years)	DHS[30]	Decrease between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
	Proportion of young people aged 18-24 who had sexual intercourse before age 18, by sex and age (aged 18-19 years, aged 20-24 years)	DHS[30]	Decrease between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
L3. Improved care-seeking for SRHR services among young people aged 10-24 years (including HIV/STI testing and treatment, condoms and other modern methods of contraception, support for sexual assault victim-survivors, and post-abortion care)	Number of young people (aged 10-24) using a specified SRHR service, and proportion of all clients who are young people (aged 10-24 years), in a 12-month period by sex and age (aged 10-14 years; aged 15-19 years; aged 20-24 years) Specified services include: HIV counselling, testing, and treatment; diagnosis and treatment of sexually transmitted infections; counselling, provision, and referrals for modern methods of contraception (by method); antenatal care; counselling and treatment for victim-survivors of sexual assault; treatment for abortion or post-abortion care.	WHO[31]	Increase in number of visits by young people year-on-year by age group; and Increase in proportion of service users that are young people year-on-year by age group	HMIS (health facility data)
	Number of HIV tests performed, by sex and age (aged 10-14 years; aged 15-19 years; aged 20-24 years)	WHO HMIS Core[32]	Increase year-on-year by sex and age group	HMIS (health facility data)
	Number of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring, by sex and age (aged 10-14 years; aged 15-19 years; aged 20-24 years)	GSWCAH[15]	Increase year-on-year by sex and age group	HMIS (health facility data)
L4. Improved care-seeking for physical, sexual and psychological violence among young people aged 10-24 years	Number of young people (aged 10-24) using referral services for victim-survivors and/or perpetrators of physical, sexual and/or psychological violence, and proportion of all clients who are young people (aged 10-24 years), in a 12-month period by sex and age (aged 10-14 years; aged 15-19 years; aged 20-24 years).	-	Increase in number of referrals by young people year-on-year by age group; and Increase in proportion of service users that are young people year-on-year by age group	HMIS (health facility data)

Impacts

The desired high-level impacts of an FLE program include improved SRHR and positive, respectful relationships during youth (age 10-24 years) and across the lifecourse. These impacts can be assessed through population-based surveys and health system data. As for the long-term outcome indicators, observed changes cannot be directly attributed to the impact of a national FLE program. Nevertheless, it is useful to monitor indicators of impact in order to capture potential mechanisms of impact of the FLE program and identify priority areas to be promoted through the FLE program.

IMPACTS	Indicator	Indicator source	Measure of success	Data source(s)
I1. Improved sexual and reproductive health among young people aged 10-24 years	Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	SDG 3.7.2[14]	Decrease between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
	Number of deaths among girls and women aged 10-24 years due to unsafe abortion, by age (aged 10-14 years; aged 15-19 years; aged 20-24 years); or Number of obstetric and gynaecological admissions among girls and women aged 10-24 years owing to abortion, by age (aged 10-14 years; aged 15-19 years; aged 20-24 years)	ICPD, GSWCAH[15,16]	Decrease in three-year rolling average by age group	Health facility data (HMIS)
	Proportion of women of reproductive age (aged 15-19 years; aged 20-24 years; aged 25-49 years) who have their need for family planning satisfied with modern methods	SDG 3.7.1[14]	Increase between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
	STI incidence rate by sex and age (aged 10-14 years; aged 15-19 years; aged 20-24 years)	WHO HMIS Core[32]	Increase in number of STI tests year-on-year by sex and age group; and Decrease in STI incidence rate year-on-year by sex and age group (to be interpreted with caution in the context of increased testing rates)	Health facility data (HMIS)
	Proportion of female adolescents under 15 years of age who have had 2 doses of Human Papillomavirus (HPV) vaccine	Healthy Islands Monitoring Framework (HIMF)[33]	More than 80 percent of female adolescents aged 10-14 years have had 2 doses of HPV vaccine More than 95 percent of female adolescents have had 2 doses of HPV vaccine at age 15	HMIS (routine immunisation program)
	Proportion of men and women aged 15-24 with basic knowledge about SRH services and rights (aged 15-19 years; aged 20-24 years)	GSWCAH[15]	Increase between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)

IMPACTS	Indicator	Indicator source	Measure of success	Data source(s)
I2. More positive, respectful, and gender-equitable relationships between young people aged 10-24 years and throughout the lifecourse	Percentage of women and men 15-49 years old who consider a husband to be justified in hitting or beating his wife for at least one of the specified reasons, i.e., if his wife burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations, by age	UNICEF[34]	Decrease between survey timepoints by sex and age group	Population-based survey (e.g. DHS, MICS)
	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	SDG 5.2.1[14]	Decrease between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence	SDG 5.2.2[14]	Decrease between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (by age)	SDG 5.6.1[14]	Increase between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)
	Proportion of time spent on unpaid domestic chores and care work, by sex, age and location	SDG 5.4.1[14]	Reduced disparity between women and men, between survey timepoints by age group	Population-based survey (e.g. DHS, MICS)

Proposed data sources

The data sources proposed below are not specific to a particular national context, and are not tailored to any country's existing routine data collection or data management systems, including EMIS. The proposed data sources would need to be adapted, through close consultation with ministry and school stakeholders, to align with and strengthen existing country systems for data collection and management.

Curriculum checklist

Indicators addressed by this data source: P1, P2, O2-O4

A checklist that defines core content by student age according to ITGSE guidance, as well as outlining optimal features of the curriculum development process. Curriculum development officers could complete this checklist when developing or reviewing a curriculum module, to be included as an appendix when the module is submitted for approval. All checklist items should be ticked off before the module is submitted for approval. Checklist completion could be recorded in EMIS together with the record of the approved module.

Teacher-training curriculum checklist

Indicators addressed by this data source: P3

A checklist that defines core content for pre-service and in-service training according to ITGSE guidance. Staff responsible for developing or reviewing teacher-training curriculum modules could complete this checklist, to be included as an appendix when the module is submitted for approval. All checklist items should be ticked off before the module is submitted for approval. Checklist completion could be recorded in EMIS together with the record of the approved module.

Referral SOP

Indicators addressed by this data source: P4, P5

A standard operating procedure (SOP) developed by school staff and leadership, to guide school staff in referring students to youth-friendly health and social services, including services for SRHR and services for victims and/or perpetrators of violence. Each referral SOP is unique to a single school. The referral SOP should be reviewed at least every 12 months to ensure the information about available services is up to date. Ideally, the service(s) listed in the SOP should co-sign the SOP to indicate their agreement on the quality and range of services to be offered to young people aged 10-24 years, and their understanding of the requirements of youth-friendly service delivery. Teachers should be trained on the referral SOP at least annually. School leadership (e.g. school principal) is responsible for completing the SOP. The SOP should be included in the annual school census submitted to the Ministry of Education and its completion should be recorded in EMIS. If referral services include school-based health services, the SOP needs to specify whether these school-based health services are permitted to offer youth-friendly sexual and reproductive health services, and how many health providers at school-based services have recently been trained in offering youth-friendly SRHR services.

HMIS (health facility and program data)

Indicators addressed by this data source: P6, L3, L4

Data available through the existing HMIS, including routine data as well as data from health facility assessments and the immunisation program, on service availability, service uptake, staff training, and cause-specific mortality.

Annual school census

Indicators addressed by this data source: O1, O6, O8-O11

Specific questions could be added to the annual census routinely completed by the principal and other school leaders and submitted to the Ministry of Education. Principals could use this annual school census to report on items including community sensitisation activities, school regulations and guidelines for teachers and students, and resourcing. Each school's up-to-date referral SOP should be submitted with the annual school census and it may be appropriate to include specific questions on the content and development of the referral SOP in the annual school census.

Teacher KAP survey

Indicators addressed by this data source: O1, O5-O8, O10, O11

Brief knowledge, attitude and practice (KAP) surveys conducted with all teachers involved in delivering FLE, to explore topics including their access to training, values they impart through their teaching, and teaching methods they use. It is recommended that these surveys be incorporated into learning materials so that they are easily accessible. Surveys should be conducted at the end of Term 1 and the end of the school year, with some topics assessed in both surveys (indicated in the evaluation matrix as T1, T4) and other topics assessed only at the beginning (T1) or the end (T4) of the school year.

Student KAP survey

Indicators addressed by this data source: O6-O9, O11, S1-S7

Surveys conducted with all students enrolled in school grades that complete FLE. Student surveys are designed to capture desired changes in student knowledge, attitude and practice over the school year, using validated measures so that student scores can be compared between schools and over time. Student surveys are also designed to triangulate teachers' and principals' reports of class content and teaching methods. Surveys should be conducted at the end of Term 1 and the end of the school year, with some topics assessed in both surveys (indicated in the evaluation matrix as T1, T4) and other topics assessed only at the beginning (T1) or the end (T4) of the school year.

Population-based survey

Indicators addressed by this data source: L1, L2, I1, I2

Surveys using random sampling that provide reliable national data on health and wellbeing indicators, such as Demographic and Health Surveys (DHS) or Multiple Indicator Cluster Surveys (MICS). Surveys are likely to be conducted in accordance with national guidelines and should be conducted regularly. These surveys can be used to monitor trends in young people's SRHR and broader wellbeing, which can guide reflection on the potential impact of existing FLE activities, and provide insight into young people's SRHR and wellbeing needs that can be addressed through a quality FLE program. However, it is not feasible to use population-based survey data to attribute observed changes directly to the FLE program. Additionally, some indicators (e.g. L3) should be interpreted together with available data on the quality of SRHR services provided. To assess indicator L1, the Sexual Relationship Power Scale (SRPS) is recommended for inclusion in a population-based survey although to date it has not been routinely used in DHS or MICS surveys.

Next steps

The sample theory of change and sample evaluation matrix presented in this guidance have been derived from global normative guidance on monitoring and evaluation for quality, effective FLE programs. This material is available to be adapted to align with country-specific priorities for the national FLE program, and local data collection and data management systems and processes. The adaptation process requires close consultation and involvement from country stakeholders, including representatives from the Ministry of Education and school leadership, as well as stakeholders familiar with health facility data management and/or HMIS and population-based surveys (e.g. DHS, MICS).

To translate the material in this guidance into concrete actions to promote quality national FLE programs through effective monitoring, the following activities are suggested, to be conducted separately with each country:

- Review the sample theory of change and adapt to local priorities for the FLE program, ensuring alignment with evidence-based principles for comprehensive sexuality education as outlined in ITGSE;
- Adapt proposed data sources and data collection mechanisms to national and subnational data collection and data management systems;
- Work with curriculum development officers and other relevant stakeholders involved in developing and updating student and teacher-training curricula, to integrate curriculum checklists into these materials and their approval processes;
- Develop, pilot-test and refine tools (e.g. Teacher KAP survey, Student KAP survey) based on agreed final indicators; and
- Integrate the proposed evaluation matrix with monitoring and evaluation of out-of-school FLE.

References

1. UNESCO, UNAIDS Secretariat, UNFPA, UNICEF, UN Women, WHO. International technical guidance on sexuality education: An evidence-informed approach (Revised edition). Paris: UNESCO, 2018.
2. Pan American Health Organization, WHO. Promotion of sexual health: Recommendations for action. Washington, D.C.: PAHO, 2000.
3. WHO. Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002. Geneva: WHO, 2006.
4. Amaugo LG, Papadopoulos C, Ochieng B, Ali N. The effectiveness of HIV/AIDS school-based sexual health education programmes in Nigeria: A systematic review. *Health Education Research* 2014; **29**(4): 633-48.
5. Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD. School based sex education and HIV prevention in low- and middle-income countries: A systematic review and meta-analysis. *PLoS One* 2014; **9**(3): e89692.
6. Tolli MV. Effectiveness of peer education interventions for HIV prevention, adolescent pregnancy prevention and sexual health promotion for young people: A systematic review of European studies. *Health Education Research* 2012; **27**(5): 904-13.
7. Pound P, Langford R, Campbell R. What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *BMJ Open* 2016; **6**(9).
8. UNFPA. The evaluation of Comprehensive Sexuality Education programmes: A focus on the gender and empowerment outcomes. New York: UNFPA, 2015.
9. UNFPA. Operational guidance for comprehensive sexuality education: A focus on human rights and gender. New York: UNFPA, 2014.
10. UNESCO. Sexuality Education Review and Assessment Tool (SERAT) 3.0. Paris: UNESCO, 2020.
11. Cornu C, Liu Y. Development of SDG thematic indicator 4.7.2 (TCG4/17). Paris: UNESCO, 2018.
12. Technical Cooperation Group on the Indicators for SDG4. Target 4.7 Global Citizenship. 2017. http://tcg.uis.unesco.org/target-4-7-global-citizenship/.
13. Keogh SC, Stillman M, Leong E, et al. Measuring the quality of sexuality education implementation at the school level in low-and middle-income countries. *Sex Education* 2020; **20**(2): 119-37.
14. UNSD. Global SDG indicators database. New York: UNSD; 2020.
15. WHO. Indicator and monitoring framework for the Global Strategy for Women's, Children's and Adolescents' Health. Geneva: WHO, 2016.
16. United Nations. Framework of Actions for the follow-up to the Programme of Action of the International Conference on Population and Development: United Nations, 2014.
17. UNFPA Pacific Sub Regional Office (PSRO). A Transformative Agenda for women, adolescents and youth in the Pacific: Towards zero unmet need for family planning 2018-2022. Suva: UNFPA PSRO, 2018.
18. Cleland J. Illustrative questionnaire for interview-surveys with young people: Asking young people about sexual and reproductive behaviors. Geneva: WHO, 2001.
19. Luszczynska A, Scholz U, Schwarzer R. The general self-efficacy scale: multicultural validation studies. *The Journal of Psychology* 2005; **139**(5): 439-57.
20. Schwarzer R, Jerusalem M. The general self-efficacy scale (GSE). *Anxiety, Stress and Coping* 2010; **12**(1): 329-45.
21. Upadhyay UD, Danza PY, Neilands TB, et al. Development and validation of the sexual and reproductive empowerment scale for adolescents and young adults. *Journal of Adolescent Health* 2020.
22. Facione PA, Facione NC. The California Critical Thinking Skills Test - test manual. Millbrae, California: California Academic, 1994.
23. Miri B, David BC, Uri Z. Purposely teaching for the promotion of higher-order thinking skills: A case of critical thinking. *Research in Science Education* 2007; **37**(4): 353-69.
24. Ramiro-Sánchez T, Ramiro MT, Bermúdez MP, Buela-Casal G. Sexism in adolescent relationships: A systematic review. *Psychosocial Intervention* 2018; **27**(3): 123-32.
25. De Lemus S, Castillo M, Moya M, Padilla JL, Ryan E. Elaboración y validación del Inventario de Sexismo Ambivalente para Adolescentes. *International Journal of Clinical and Health Psychology* 2008; **8**: 537-62.
26. Jaruseviciene L, De Meyer S, Decat P, et al. Factorial validation of the Attitudes toward Women Scale for Adolescents (AWSA) in assessing sexual behaviour patterns in Bolivian and Ecuadorian adolescents. *Global Health Action* 2014; 7(1): 23126.
27. Ruel C, Lavoie F, Hébert M, Blais M. Gender's role in exposure to interparental violence, acceptance of violence, self-efficacy, and physical teen dating violence among Quebec adolescents. *Journal of Interpersonal Violence* 2020; **35**(15-16): 3079-101.
28. Bogen KW, Mulla MM, Orchowski LM. Gender-equitable attitudes, rape myth acceptance, and perceived peer acceptance of violence among high school students: an examination of gender and athletic involvement. *Journal of Interpersonal Violence* 2020: 0886260520958649.
29. Pulerwitz J, Gortmaker SL, DeJong W. Measuring relationship power in HIV/STD research. *Sex Roles* 2000; **42**(7-8): 637-60.
30. Croft TN, Marshall AMJ, Allen CK, group atGtDSw. Guide to DHS statistics. DHS-7 (version 2). Rockville, Maryland, USA: ICF, 2018.
31. MEASURE evaluation. Family planning and reproductive health indicators database: Adolescent and youth sexual and reproductive health. Chapel Hill, North Carolina: University of North Carolina at Chapel Hill; n.d.
32. 2018 Global Reference List of 100 Core Health Indicators (plus health-related SDGs). Geneva: WHO, 2018.
33. Monitoring progress towards the vision of healthy islands in the Pacific: second progress report 2019. Manila: World Health Organization Regional Office for the Western Pacific, 2020.
34. UNICEF. Attitudes and social norms on violence. New York: UNICEF Data; 2020.

Appendix 1 Recommended high-level indicator for reporting on FLE

The updated International Technical Guidance on Sexuality Education, issued by UNESCO in 2018, recommends the following indicator for use by countries within their Education Management Information System (EMIS) as a minimum high-level indicator for reporting on family life education (FLE):[2]

Did students at your school receive comprehensive life-skills based HIV and sexuality education in the previous academic year?	☐ **Yes** ☐ **No**
If Yes, indicate which of these topics were covered in the life skills-based HIV and sexuality education program:	
1. Teaching on generic life skills	☐ Yes ☐ No
2. Teaching on sexual reproductive health/sexuality education	☐ Yes ☐ No
3. Teaching on HIV transmission and prevention.	☐ Yes ☐ No

This indicator is intended to capture the quality, comprehensiveness and coverage of FLE. The indicator aligns with and enables countries to report against Sustainable Development Goal thematic indicator 4.7.2.[3] It has been recommended by UNESCO and the UNAIDS Inter-Agency Task Team on HIV and Health Education (IATT) since 2013 as the core indicator to assess progress towards implementation of life-skills based HIV and sexuality education in all schools.[4]

2 UNESCO, UNAIDS Secretariat, UNFPA, UNICEF, UN Women, WHO. International technical guidance on sexuality education: An evidence-informed approach (Revised edition). Paris: UNESCO, 2018.
3 Technical Cooperation Group on the Indicators for SDG4. Target 4.7 Global Citizenship. 2017. http://tcg.uis.unesco.org/target-4-7-global-citizenship/.
4 UNESCO. Measuring the education sector response to HIV and AIDS: Guidelines for the construction and use of core indicators. Paris: UNESCO, 2013.

Measurement and reporting

Principals report against this indicator annually, for example through the EMIS Annual School Census. The FLE program is considered to cover each of the three core topics listed in the indicator if the essential content outlined in Table 1 below is included. Desirable content is also specified in the indicator. Essential content has a substantial direct impact on HIV prevention, while desirable topics have an indirect impact on HIV prevention yet are important to address within a comprehensive sexuality education program.[5]

Table 1 Essential and desirable content for life-skills based HIV and sexuality education

Generic life skills	
Essential	• Decision-making/assertiveness • Communication/negotiation/refusal • Human rights empowerment
Desirable	• Acceptance, tolerance, empathy and non-discrimination • Other generic life skills
Sexual and reproductive health (SRH)/Sexuality education	
Essential	• Human growth and development • Sexual anatomy and physiology • Family life, marriage, long-term commitment and interpersonal relationships • Society, culture and sexuality: values, attitudes, social norms and the media in relation to sexuality • Reproduction • Gender equality and gender roles • Sexual abuse/resisting unwanted or coerced sex
Sexual and reproductive health (SRH)/Sexuality education	
Essential	• Condoms • Sexual behaviour (sexual practices, pleasure and feelings) • Transmission and prevention of sexually transmitted infections (STIs)
Desirable	• Pregnancy and childbirth • Contraception other than condoms • Gender-based violence and harmful practices/rejecting violence • Sexual diversity • Sources for SRH services/seeking services • Other content related to SRH/sexuality education
HIV and AIDS-related specific content	
Essential	• Transmission of HIV • Prevention of HIV: practising safer sex including condom use • Treatment of HIV
Desirable	• HIV-related stigma and discrimination • Sources of counselling and testing services/seeking services for counselling, treatment, care and support • Other HIV and AIDS-related specific content

5 UNESCO, UNAIDS Secretariat, UNFPA, UNICEF, UN Women, WHO. ibid.

Appendix 2 Recommended curriculum content

The updated Sexuality Education Review and Assessment Tool (SERAT)[6] issued in 2020 contains a comprehensive list of curriculum content that aligns with the content recommended in the evidence-based *International Technical Guidance on Sexuality Education* (ITGSE) issued by UNESCO in 2018.[7]

To develop the curriculum checklists to be used to assess indicators P1, P2, and O2-O4 in the proposed monitoring and evaluation framework, we suggest that an agreed subset of this list of curriculum content be selected in consultation with Ministry and school stakeholders. We recommend that items from each of the 8 core areas recommended in ITGSE be included, for each age group for which FLE is taught.

Core area 1: Relationships
Age 5-8 years
☐ express respect for different kinds of families (e.g. two-parent, single-parent, child-headed; guardian-headed, extended, nuclear, and non-traditional families)
☐ reflect on their feelings about men's and women's roles and responsibilities within the family, including their own
☐ value a diversity of friendships (including differences in gender, ability and health status)
☐ demonstrate ways to show trust, respect, understanding, empathy and sharing with a friend
☐ explain what is friendship and list characteristics of healthy and unhealthy relationships
☐ demonstrate ways to show tolerance, inclusion and respect for others and treat all people with dignity
☐ acknowledge that even though family structures might differ, they are all valuable
☐ recall that some marriages end in separation, divorce and/or death
☐ agree that marriage should be entered into by adults and free of coercion
Age 9-12 years
☐ reflect on how a family value guided a decision that they made
☐ express support for gender equitable roles and responsibilities within the family
☐ reflect on the way in which they express friendship and love to another person changes as they grow older
☐ recognize how equality is a part of healthy relationships
☐ define stigma and discrimination and identify ways that they are harmful
☐ acknowledge that it is important to show tolerance, inclusion and respect for others including those who are stigmatized or discriminated against
☐ demonstrate ways to speak out against and counter harassment or bullying
☐ list negative consequences of child, early and forced marriage on the child, the family and society
☐ describe ways that culture, religion, society and laws affect long-term commitments, marriage and parenting

6 UNESCO. Sexuality Education Review and Assessment Tool (SERAT) 3.0. Paris: UNESCO, 2020.
7 UNESCO, UNAIDS Secretariat, UNFPA, UNICEF, UN Women, WHO. International technical guidance on sexuality education: An evidence-informed approach (Revised edition). Paris: UNESCO, 2018.

Age 12-15 years
☐ recognize that love, cooperation, gender equality, and mutual respect are important for healthy family functioning and relationships
☐ demonstrate ways to have a positive influence on peers and to avoid being negatively influenced by a friend or a peer
☐ distinguish between emotions associated with love, friendship, infatuation and sexual attraction
☐ recognize that inequality and differences in power within relationships can be harmful
☐ examine consequences of stigma and discrimination on people's sexual and reproductive health and rights
☐ apply strategies for resolving conflict and misunderstandings with parents/guardians
☐ list responsibilities of parents
☐ compare the different ways that adults can become parents (e.g. intended and unintended pregnancy, adoption, fostering, with medical assistance and surrogate parenting)
☐ assert that everyone should be able to decide if and when to become a parent, including but not limited to people with disabilities, and people living with HIV
Age 15-18 years
☐ describe how siblings, parents/guardians or extended family can provide support to a young person who discloses or shares information related to sexual relationships or health
☐ demonstrate ways to avoid unhealthy sexual relationships and how to have a healthy sexual relationship
☐ recognize that sexual behaviour is not a requirement for expressing love, and explain what is a sexual relationship
☐ advocate for inclusion, non-discrimination, and respect for diversity
☐ acknowledge that excluding or expelling a student because of pregnancy or becoming a parent is a violation of human rights
☐ acknowledge that some people may want to become parents; some people may not want to; not everyone is able to become a parent; and some people may have become a parent without wanting to
☐ critically assess factors that impact their own opinion about if, why, and when to get married and if, why, and when to have children
☐ categorize key physical, emotional, economic, health and educational needs of children and associated responsibilities of parents
☐ perceive the importance of equality, respect and shared responsibilities between parents

Core area 2: Values, rights, culture and sexuality
Age 5-8 years
☐ explain that values are strong beliefs held by individuals, families and communities that guide decisions about life and relationships
☐ agree that individuals, peers, families and communities may have different values
☐ share important personal values such as equality, respect, acceptance and tolerance
☐ define human rights
☐ acknowledge that everyone has human rights that should be respected
☐ express support for human rights
☐ list sources of information (e.g. family, individuals, peers, media) that help them understand themselves, their feelings and their bodies
☐ demonstrate how they would ask questions they may have about their feelings and their body to a trusted adult
Age 9-12 years
☐ acknowledge that no one should marry against their consent, and that all adults should be able to decide if, when and whom to marry
☐ acknowledge that parenting is the responsibility of both men and women
☐ identify cultural, religious or social beliefs and practices related to sexuality that have changed over time
☐ recognize children's rights that are outlined in national laws and international agreements (e.g. Universal Declaration of Human Rights and the Convention on the Rights of the Child)
☐ demonstrate respect for diverse practices related to sexuality and all people's human rights
☐ identify sources of values and attitudes that inform what and how one learns about sex and sexuality (e.g. parents, guardians, families, friends, communities, media)
Age 12-15 years
☐ describe their own personal values in relation to a range of sexuality and reproductive health issues, and how these may affect their decisions
☐ recognize the importance of being tolerant of and having respect for different values, beliefs and attitudes
☐ discuss local and/or national laws impacting sexual and reproductive health rights
☐ demonstrate respect for the human rights of all people, including rights related to sexual and reproductive health
☐ question social and cultural norms that impact sexual behaviour in society
Age 15-18 years
☐ appreciate how their values guide sexual behaviours
☐ demonstrate ways to resolve conflict with family members due to differing values
☐ analyze local and/or national laws and policies concerning: - CEFM - FGM/C - non-consensual surgical interventions on intersex children - forced sterilization - age of consent - gender equality - sexual orientation - gender identity - abortion - rape - sexual abuse - sex trafficking - people's access to sexual and reproductive health services and reproductive rights
☐ recognize why it is important to promote human rights that impact sexual and reproductive health
☐ reflect on the social and cultural norms that they value and how these influence their personal beliefs and feelings about sexuality and sexual behaviour

Core area 3: Understanding gender
Age 5-8 years
☐ define gender and biological sex and describe how they are different
☐ acknowledge that perceptions about sex and gender are influenced by many different sources in their environment
☐ recognize that treating people unfairly because of their gender in any way is a violation of human rights
☐ identify different forms of GBV (incl. psychological and harmful practices)
☐ recognize that GBV can be committed by different kinds of perpetrators of GBV (including trusted adults) and in different locations (e.g. school, home or in public)
☐ recognize that female genital mutilation/cutting is a form of GBV that violates girls' rights
Age 9-12 years
☐ identify examples of how social norms, cultural norms, and religious beliefs can influence gender roles
☐ recognize different gender identities and demonstrate respect for all
☐ demonstrate ways of promoting gender equality in their relationships at home, school and in the community
☐ question the fairness of existing gender roles
☐ list types of GBV, different perpetrators and spaces where GBV might occur
☐ recognize that child marriage and female genital mutilation/cutting are violations of human rights and illegal in most countries
☐ recognize that gender inequality and gender stereotypes contribute to unequal treatment, bullying, discrimination, abuse and GBV
Age 12-15 years
☐ analyze the impact of gender norms and gender stereotypes on romantic relationships (both norms relating to masculinity and femininity)
☐ recall social norms that shape how society portrays men, women and people of diverse sexual orientation and gender identity
☐ demonstrate ways to treat people without gender bias
☐ list ways that gender roles, inequality and discrimination affect decisions about sexual behaviour, contraceptive use and life-planning
☐ acknowledge that gender equality is a part of healthier sexual relationships
☐ recognize that witnesses and those aware of GBV and harmful practices can take safe steps to intervene
☐ acknowledge that female genital mutilation/cutting and child marriage are harmful practices reflecting deeply rooted social and gender norms
Age 15-18 years
☐ critically assess their own level of gender bias and analyze gender bias within their community
☐ analyze social norms that contribute to homophobia and transphobia and their consequences
☐ acknowledge that gender inequality and power differences can impact sexual behaviours and the ability to make, and act on, safe choices e.g. condom use, accessing SRH services
☐ recognize that intimate partner violence can take many different forms (e.g. psychological, physical, sexual)
☐ recognize that intimate partner violence is wrong and that it is possible to leave an abusive relationship
☐ advocate for gender equality and changing harmful social norms that promote or support harmful practices and other forms of GBV

Core area 4: Violence and staying safe
Age 5-8 years
☐ acknowledge that bullying, violence and child abuse are wrong, and are never the victim's fault
☐ acknowledge that bullying, violence and child abuse can be carried out by an adult, someone known and trusted, or online
☐ demonstrate safe actions that they can take to respond to bullying, violence, GBV, and child abuse in family, school and community settings, including identifying trusted adults with whom to approach
☐ recognize types of violence that can take place between parents or romantic partners (e.g. physically hurting, saying mean things, or forcing the partner to do something)
☐ acknowledge that everyone has the right to decide who can touch their body, where, and in what way
☐ demonstrate how to respond if someone is touching them in a way that makes them feel uncomfortable (e.g. say 'no', 'go away', and talk to a trusted adult)
☐ list benefits and potential dangers of the Internet and social media
☐ demonstrate ways to talk to a trusted adult if something they have done or seen on the Internet or social media makes them feel uncomfortable or scared
Age 9-12 years
☐ recognize that child sexual abuse is illegal and that there are authorities and services available to assist those who have experienced it
☐ identify the effects of all forms of violence and abuse for the victim, couple, family and society
☐ communicate assertively to maintain privacy and counter unwanted sexual attention
☐ explain that during puberty, privacy about one's body and private space become more important for both boys and girls
☐ demonstrate how to decide what information to share with whom on social media
☐ perceive that sexually explicit media can be misleading through inaccurate portrayals about men, women and sexual relations
Age 12-15 years
☐ compare and contrast bullying, psychological violence, physical violence, sexual abuse, sexual assault, intimate partner violence
☐ acknowledge that all these forms of violence by adults, young people and people in positions of power are always a violation of human rights
☐ express ways in which they can defend their right to privacy and bodily integrity
☐ express consent and not giving consent in relation to their personal boundaries regarding sexual behavior
☐ acknowledge that there are ways to counter unwanted sexual attention that can come from the Internet, cell phones and social media
☐ summarize ways that sexually explicit media can be harmful, and where to report these harms and get help
☐ demonstrate how to report sexual abuse, sexual assault, intimate partner violence and bullying, including at school
Age 15-18 years
☐ appreciate the importance of speaking out against violence and human rights violations in all spaces including at school, in the home, online and within the community
☐ recognize that consensual sexual behaviour is an important part of a healthy sexual relationship
☐ demonstrate ways to communicate giving and refusing consent and to recognize consent or lack of consent
☐ acknowledge that social media use has many benefits, but can also result in unsafe situations or violations of law
☐ acknowledge that sexually explicit media can reinforce harmful gender stereotypes and can normalize violent or non-consensual behaviour
☐ reflect on how sexually explicit media can impact their self-image, self-confidence, self-esteem and perception of others as a result of unrealistic portrayals of men, women and sexual behaviour

Core area 5: Skills for health and wellbeing
Age 5-8 years
☐ describe examples of good and bad peer influence
☐ demonstrate ways to counter negative peer pressure, including modeling a positive behaviour
☐ identify examples of decisions that they or others have made that had either good or bad consequences
☐ demonstrate understanding of circumstances that can help them make a good decision
☐ identify the difference between healthy and unhealthy communication, including in terms of consequences for relationships
☐ demonstrate verbal and non-verbal ways to say 'yes' and 'no'
☐ acknowledge that gender roles can affect the way that people communicate with each other
☐ acknowledge that not all information provided by different forms of media is true
☐ acknowledge that all people have the right to be protected and supported
Age 9-12 years
☐ describe the main steps in decision-making
☐ apply the decision-making process to address learners' problems
☐ demonstrate the ability to refuse to do something that they don't want to do
☐ realize that their decisions are influenced by numerous factors
☐ recognize that negotiation requires mutual respect, cooperation and often compromise from all parties
☐ demonstrate effective ways to communicate wishes, needs and personal boundaries, and listen and show respect for those of others
☐ recognize the power of media to influence values, attitudes and behaviour relating to sexuality and gender
☐ question how men and women are portrayed in the media
☐ demonstrate ways to seek out and access help in the school or wider community for problems like abuse, harassment, bullying, illness, violence in their family or surroundings, etc.
Age 12-15 years
☐ describe ways that gender and social norms affect sexual decisions and behaviours
☐ apply the decision-making process to address sexual and/or reproductive health concerns
☐ demonstrate assertiveness by speaking out when someone is being bullied or pressured into making a sexual decision that they don't want to take
☐ describe ways that alcohol and drugs can impact decision-making on sexual behaviour
☐ understand that there are many factors that influence people's decisions about sexual behaviour, some of which are out of their control like poverty, gender inequality and violence
☐ analyze the implications of verbal and nonverbal communication that contradict each other, including how gender roles and expectations can impact these
☐ demonstrate confidence in using negotiation and refusal skills with a romantic partner
☐ reflect on how unrealistic images about sexuality and sexual relationships can affect their perceptions of gender and self-esteem
☐ describe characteristics of good sources of help and support (including maintaining confidentiality and protecting privacy)
☐ understand that there are places where people can access support for sexual and reproductive health (e.g. counseling, testing and treatment for STIs/HIV; services for modern contraception, sexual abuse, rape, domestic and GBV, abortion and postabortion care and stigma and discrimination)

Age 15-18 years
☐ demonstrate ways to counter negative gender and social norms in sexual decision-making
☐ analyze potential social and health consequences of decisions related to sexual behaviour on the individual, family, and society
☐ identify national laws that affect what young people can and cannot do related to sexual behaviour (e.g. age of sexual consent, access to health services including contraception, STI/HIV status, same sex sexual behaviour)
☐ demonstrate effective communication of personal needs and sexual limits, including assertiveness and negotiation skills
☐ demonstrate ways to challenge gender stereotypes and inaccurate portrayals of sexuality and sexual relationships in the media
☐ identify where to access relevant sexual and reproductive health services or assistance

Core area 6: Human body and development
Age 5-8 years
☐ recognize that being curious about and touching their bodies, including their genitals, is completely normal
☐ acknowledge that every person's body deserves respect above and beyond differences and regardless of changes over time
☐ identify how a woman's body changes during a pregnancy
☐ identify the physical and emotional changes that occur during puberty
☐ express things that they like about their own body
Age 9-12 years
☐ recall that sexual intercourse can - but does not always - lead to pregnancy
☐ acknowledge that having erections, wet dreams or other sexual responses are a normal part of puberty
☐ appreciate the importance of personal hygiene and sanitation practices, including menstrual hygiene
☐ recognize that it is important for all girls to have access to sanitary pads and other menstrual aids, clean water and private toilet facilities during their menstruation
☐ demonstrate ways to find credible information about puberty
☐ demonstrate how the menstrual cycle works
☐ acknowledge that physical appearance is determined by heredity, environment and health habits and does not determine a person's worth as a human being
Age 12-15 years
☐ recall that puberty occurs at different times for different people and has different effects on boys and girls
☐ recognise that puberty may be particularly challenging for some children, especially those who are gender non-conforming, transgender or intersex
☐ understand that there is a difference between reproductive function and sexual feelings
☐ recognize the important role that hormones play in puberty and pregnancy and in the development of reproductive organs and sexual functions
☐ acknowledge how religious, societal and personal views about sex, gender and reproduction are distinguished from the biological aspects
☐ acknowledge that teasing, shaming or stigmatizing others based on the changes of puberty is hurtful and may have long-lasting psychological impacts
☐ reflect on and articulate their own perspectives on sex, gender and reproduction
☐ understand common practices that people use to try to change their appearance (e.g. using diet pills, steroids, bleaching cream), as well as various disorders connected to body image (e.g. anxiety and eating disorders such as anorexia and bulimia)
☐ critically assess gendered standards of beauty that can drive people to want to change their appearance

Age 15-18 years
☐ analyze the role hormones play in one's emotional and physical changes over their lifetime
☐ summarize the sexual and reproductive capacity of men and women over the life cycle
☐ acknowledge that people are sexual beings throughout the life cycle
☐ list options for those who would like to conceive but who are experiencing infertility
☐ recognize that the stigma related to infertility can be based in gendered expectations
☐ reflect on their own body image and how it can affect self-esteem, sexual decision-making and subsequent sexual behaviours
☐ demonstrate ways to challenge unrealistic standards about physical appearance

Core area 7: Sexuality and sexual behaviour
Age 5-8 years
☐ understand that it is natural for humans to enjoy their bodies and being close to others
☐ recognize that there are appropriate and inappropriate language and behaviours related to how we express our feelings for and closeness to others
☐ understand that people can show love for others in different ways, including kissing, hugging, touching, and sometimes sexual behaviour
☐ define 'good touch' and 'bad touch'
Age 9-12 years
☐ understand that sexuality is a healthy part of being human that involves emotional and physical attraction to others
☐ acknowledge that it is natural to be curious and have questions about sexuality
☐ describe ways that human beings feel pleasure from physical contact (e.g. kissing, touching, caressing, sexual contact) throughout their life
☐ acknowledge that discrimination against people who are attracted to the same sex, or who are believed to be attracted to the same sex is wrong and can have negative effects on these individuals
☐ communicate and understand different sexual feelings and talk about sexuality in an appropriate way
☐ understand that masturbation among girls and boys does not cause physical or emotional harm but should be done in private
Age 12-15 years
☐ question myths about sexual behaviours
☐ understand that sexual stimulation involves physical and psychological aspects, and people respond in different ways, at different times
☐ appreciate the importance of respecting the different ways that people express sexuality across cultures and settings
☐ demonstrate ways to manage emotions related to sexual feelings, fantasies, and desires
☐ recall that non-penetrative sexual behaviours are without risk of unintended pregnancy, offer reduced risk of STIs, including HIV, and can be pleasurable
☐ recognize that each person's decision to be sexually active is a personal one, which can change over time and should be respected at all times
☐ make well-informed choices about their sexual behaviour
☐ recognize that intimate relationships involving transactions of money or goods increase unequal power relations can increase vulnerability and limit the power to negotiate safer sex

Age 15-18 years
☐ explain and analyze the complexity of sexuality and how it is multifaceted and includes biological, social, psychological, spiritual, ethical and cultural components
☐ reflect on how gender norms and stereotypes influence people's expectations and experience of sexual pleasure
☐ recognize that understanding their body's sexual response can help them understand their body, and can help identify when things are not functioning properly so they can seek help
☐ justify why good communication can enhance a sexual relationship
☐ consider and apply risk reduction strategies to prevent pregnancy and STIs, including HIV and/or to prevent transmission of STIs to others

Core area 8: Sexual and reproductive health
Age 5-8 years
☐ recall that pregnancy is a natural biological process that begins when a sperm and egg unite and implant into the uterus
☐ explain that the choice whether, when and with whom to have children is one that each individual should be able to make
☐ state that people living with HIV, who have access to the right care, treatment and support, are able to live fully productive lives and have children if they wish
☐ recognize that people living with HIV deserve equal respect, love, care and support
☐ describe the concepts of 'illness' and 'health,' including ways that people can protect their health
☐ recall that even though someone has an illness, they can still look and feel healthy
Age 9-12 years
☐ understand the importance of informed decision-making (e.g. advantages and disadvantages, impact on future plans) on sexual behaviour, including whether to delay sex or become sexually active
☐ reflect on the reasons why people may accept to have unwanted sex
☐ correct myths about modern contraceptives and abortion
☐ acknowledge that the prevention of pregnancy and STIs through contraception and condom use is the responsibility of both sexual partners
☐ recognize that women and girls have the right to access all services and information that help them to act upon their decisions related to pregnancy
☐ list the most common STIs, (e.g. HIV, HPV, herpes, chlamydia, gonorrhoea) among youth in their community, and the most common modes of transmission
☐ where available, describe at what age and where the vaccine for genital human papillomavirus (HPV) can be accessed
☐ describe ways to reduce the risk of acquiring or transmitting HIV, before (i.e. using a condom and where available, VMMC or PrEP in combination with condoms); and after (i.e. where available, PEP) exposure to the virus
☐ explain that HIV is not a barrier for relationships, family or having a sexual life, because people with different HIV statuses can live together and be sexual partners without risk of acquiring HIV, and have children free of HIV
☐ explain that antiretroviral therapy (ART) is a lifelong daily therapy for PLHIV and that it is important to complement ART with a healthy diet and lifestyle to prevent opportunistic infections
☐ acknowledge that everyone has a responsibility to ensure safe and supportive environments for people living with HIV
☐ demonstrate where to go to get tested for STIs, including HIV

Age 12-15 years
☐ analyze methods of preventing unintended pregnancy and their associated benefits and efficacy, including male and female condoms, contraceptive pills, injectables, implants, emergency contraception, sterilization and natural contraceptive methods
☐ recognize that no sexually active young person should be refused access to contraceptives or condoms on the basis of their marital status, their sex or their gender
☐ demonstrate ways to access sources of contraception
☐ demonstrate how to use a condom correctly
☐ express preferences about if and when to become pregnant
☐ conclude that discrimination against people on the basis of their HIV status is illegal and contrary to their human rights
☐ understand the importance of knowing one's HIV status and accessing treatment in response to the HIV epidemic, particularly for (young) key population groups
☐ explain the settings and circumstances under which personal vulnerability to HIV increases, including relationships in which there is an unequal power dynamic between sexual partners
☐ state that everyone has a right to voluntary, informed, and confidential HIV testing and should not be required to disclose their HIV status
☐ support the right for everyone, including PLHIV, to express and act upon their sexual feelings and love for others, including through long-term commitments, should they choose to do so
☐ demonstrate skills in negotiating safer sex and refusing unwanted and unsafe sexual practices
Age 15-18 years
☐ identify ways in which men and boys can support women and girls in ensuring a healthy pregnancy
☐ examine factors (e.g. perceived risk, cost, accessibility) that help determine the most appropriate method or mix of contraceptives amongst those who are or are planning to be sexually active
☐ understand that, where legal and available through the health system, abortion is a safe option for women and girls experiencing unintended pregnancy and that unsafe abortion poses a serious health risk
☐ acknowledge that adoption, where legal and available, is one option for people who are not ready or able to become parents
☐ develop a plan for supporting a healthy pregnancy, including mental health and emotional support for the pregnant person
☐ develop a plan for accessing a preferred method of modern contraception for when they may need it
☐ identify where to access safe and confidential STI and HIV testing and other services, including PrEP and PEP
☐ acknowledge that exclusion and discrimination of certain groups in society increases their vulnerability to HIV and other STIs
☐ advocate for everyone's right, including people living with HIV, to live free of stigma and discrimination
☐ apply effective communication, negotiation and refusal skills they can use to counter unwanted sexual pressure and employ safer-sex strategies
☐ construct and practise a personal plan for health and well-being based upon an understanding of all the potential influences on their sexual decision-making

Delivering a world where
every pregnancy is wanted,
every childbirth is safe
and every young person's
potential is fulfilled

pacific.unfpa.org