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Sexuality Education across selected Muslim countries: A review to inform Malaysia's 2020-24 National Reproductive Health and Social Education Plan of Action

Prepared by UNU-IIGH for the
LPPKN Technical Working Committee
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Acronyms

Acronym	Expanded name
ACCRH	Advisory and Coordinating Committee for Reproductive Health
AFR	Adolescent Fertility Rate
AFHCs	Adolescent-friendly Health Centers
ARROW	Asian-Pacific Resource and Research Centre for Women
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CSE	Comprehensive Sexual Education
CSO	Civil Society Organization
FRHAM	Federation of Reproductive Health Associations, Malaysia
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GDI	Gender Development Index
GII	Gender Inequality Index
GNI	Gross National Income
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
ITGSE	International Technical Guidance on Sexuality Education
IVF	In Vitro fertilization
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex
LMICs	low-and middle-income countries
LPPKN	Lembaga Penduduk & Pembangunan Keluarga Negara
NCWO	National Council of Women's Organisations Malaysia
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MMR	Maternal Mortality Ratio
MWFCD	Ministry of Women, Family and Community Development
MoE	Ministry of Education
MoH	Ministry of Health
NAHP	National Adolescent Health Policy
PEERS	Reproductive Health and Social Education/Pendidikan Kesihatan Reproduktif dan Social
PEKERTI Policy	National Reproductive Health and Social Education Plan of Action
PKK	Family Health Education
NGO	Non-Governmental Organization
PHC	Primary Health Care
RTIs	Reproductive Tract Infections
SBCC	Social and Behavior Change Communication
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
SRHE	Sexual and Reproductive Health Education
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
SYPE	Survey of Young People in Egypt
TFR	Total Fertility Rate
TWC	Technical Working Committee
UHC	Universal Health Coverage
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization

UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
WHO	World Health Organization
YHCs	Youth Healthcare Centers

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EXECUTIVE SUMMARY

Malaysia's *2009-12 National Reproductive Health and Social Education Plan of Action* (referred to as PEKERTI) is being updated/reviewed for the period 2020-24 through a consultative process led by the National Population and Family Development Board (Lembaga Penduduk & Pembangunan Keluarga Negara or LPPKN), a statutory body under the Ministry of Women, Family and Community Development (MWFCD). The update is under the guidance of a Technical Working Committee (TWC), chaired by LPPKN's Deputy Director-General (Policy). The members of the TWC are key government and non-government stakeholders involved in sexual and reproductive health (SRH) including sexual and reproductive health education (SRHE). The desk review was conducted by United Nations University International Institute for Global Health (UNU-IIGH), commissioned by United Nations Population Fund (UNFPA) at the request of LPPKN.

Preparing children, adolescents and young people for the transition to adulthood where safe sexual and reproductive behaviours and choices are understood and practiced remains a priority for all governments. There is enough evidence that comprehensive sexuality education (CSE) commencing at age five is a more effective approach over abstinence-only or abstinence-plus programmes in delaying sexual initiation and reducing the negative health consequences of unprotected sex. Implementing quality CSE and providing SRH services from a human rights perspective can improve adolescents' health and educational outcomes, and accelerate the achievement of the Sustainable Development Goals (SDGs) and the International Conference on Population and Development Programme of Action (ICPD PoA).

This desk review presents the latest evidence on best practices aligned with international CSE guidelines. It compares sexuality education policies and practices across selected Sunni Muslim countries: Turkey, Egypt, Morocco, Bangladesh and Malaysia. A combination of data collection methods was used, including reviewing relevant documents and stakeholder consultations with LPPKN, UNFPA and the TWC. Despite the limited available literature on sexuality education and services across these countries, this report provides important insights to inform the update of Malaysia's 2020-24 PEKERTI Plan of Action. SRHE is a component of SRH, and one of CSE's core concepts is that it must be linked to the broader SRH services. Therefore, the scope of the review covered SRHE and SRH services.

These countries, especially Malaysia, have made notable progress in human development. There are legal and policy frameworks for SRH for matters such as age of marriage, abortion and gender-based violence. However, the implementation of SRH education in schools and the community is poor. This is reflected in the limited SRH knowledge among children, adolescents and young people. In school-based SRHE, the approach used is an abstinence-only-until-marriage, based on the common misconception that CSE might encourage early sexual activity and risk-taking behaviours. However, many young people in these countries become sexually active before marriage, reflecting a shift from traditional conservative cultural and religious practices towards more liberal behaviours. Since SRH research, education and services are commonly targeted to married couples, unmet need for contraception

among young people is underestimated, and should be addressed to prevent further STI transmission and unintended pregnancies.

The selected countries face several similar challenges in implementing SRH education. Misconceptions based on religious precepts significantly contribute to the poor progress towards implementing SRE education. In Malaysia, there is inadequate teachers' training and support; the curriculum is unclear, fragmented, and does not align with UNESCO's curriculum guidelines; SRHE programmes are not monitored or evaluated, and there is lack of participatory engagement of young people and parents. Community programmes are also limited in their reach, disadvantaging vulnerable out-of-school young people. The same is observed in Turkey, where school based SRHE is very limited. Egypt lacks the necessary institutional and political framework for SRHE, and both teachers and students are uncomfortable regarding SRH matters. SRHE remains a controversial issue in Morocco, and SRHE focuses on biological information on human reproduction. In 2012, the Bangladeshi government introduced a subject on adolescence and reproductive health, but the implementation is poor due to teachers' reluctance to teach SRHE. Because the approach used is based on sexual abstinence until marriage rather than on informed choice as recommended by international guidelines, all these countries provide minimal information on safer sex and contraception.

This review provides important insights to inform Malaysia's 2020-2024 PEKERTI to enhance the effectiveness of SRHE in formal and informal settings, that will support the achievement of Malaysia's international commitments, particularly the ICPD PoA and the SDG Agenda.

This review proposes a comprehensive, multilevel approach aligned with socio-ecological frameworks based on internationally endorsed CSE principles and guidelines, including those from UNESCO and UNFPA. The following recommendations were endorsed by the TWC. **Appendix 5** provides a comprehensive list of the recommendations.

1. Revive the LPPKN's Advisory and Coordinating Committee for Reproductive Health (ACCRH) to improve the quality of SRHE through multisectoral collaboration and coordination (involving governmental, NGOs and private partnerships), ensuring participatory planning and effective monitoring, and overseeing the implementation of the 2020-24 PEKERTI PoA across the life course (commencing from age five), as well as its full integration into SRH services and programmes.
2. Improve the SRHE curriculum and programmes by allocating adequate financial resources including personnel to build the capacity of SRH service providers and SRHE educators. Reframe SRHE as a health issue (e.g. *family health*) linked to international commitments (SDGs, ICPD PoA, Beijing Declaration and CEDAW) and appealing to contextual values and beliefs while ensuring the adaptation of right-based and gender-focused principles to Malaysia's multiracial and multifaith society.

a. Adapt the school-based CSE curriculum guidelines and empower children (aged 0-18),[1] adolescents (aged 10-19), and young people (aged 10-24) to make informed decisions by integrating four key components: rights, participation and agency; sexual and reproductive health and behaviours; gender equality and power; and positive sexuality and respectful relations.[2]
b. Integrate CSE training in the teachers' syllabus and improve training modules using a participatory teaching approach with follow up and support.
c. Engage parents in the learning process, and engage progressive community and faith-based leaders in delivering a consistent community message to increase support.
d. Improve reach and coverage of SRHE programmes addressing vulnerable communities.
e. Include older people within the PEKERTI PoA by strengthening SRH programmes and services and SRHE for the elderly.

3. Generate social support through community participation and mobilisation via mass media campaigns to advocate for greater community acceptance of SRH education and services. The campaign should incorporate religious views and cultural perspectives, engage multisectoral champions (public male and female community role models) and ensure the community is provided with relevant knowledge and skills.
4. Use peer-based models to transfer positive SRHE knowledge and attitudes among children, adolescents and young people, and introduce digital innovations to deliver SRH messages (e.g. self-care digital tools).
5. Establish a comprehensive monitoring and evaluation mechanism prior to programme implementation to avoid ineffective efforts and to ensure efficient use of available resources.
6. Form a Task Force under the ACCRH to review the 2009-2012 PEKERTI document regarding its overall structure, comprehensiveness and length. Consider updating the rationale, objectives, target population and strategies; most appropriate timeframe; and ensure publication of an official English version to facilitate international engagement.

[1] According to the following sources
- OHCHR (1989) Convention on the Rights of the Child
- The Commissioner of Law revision, Malaysia (2001) Malaysia Child Act 2001

[2] Positive sexuality education approaches strive to achieve ideal experiences, rather than solely working to prevent negative experiences. They acknowledge and address the various concerns and risks associated with sexuality, without reinforcing fear, shame or taboo of young people's sexuality or gender inequality. For further details, refer to with concepts expanded in **Box 3**, extracted from UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

1. BACKGROUND

1.1 Malaysia's National Policy and Plan of Action for Reproductive Health and Social Education (PEKERTI)

Malaysia implements its commitment to reproductive health through the National Policy and Plan of Action for Reproductive Health and Social Education (referred to as Dasar dan *Pelan Tindakan Pendidikan Kesihatan Reproduktif dan Sosial Kebangsaan* or PEKERTI). PERKERTI is a policy, plan of action (PoA) and programme. While the PoA includes all ages, the programme targets adolescents.

The National Population and Family Development Board (NPFDB), known by its Malay acronym LPPKN introduced PEKERTI 2009 following a Cabinet decision. LPPKN is a statutory agency under the Ministry of Women, Family and Community Development (MWFCD) and has overall responsibility for implementing PEKERTI. It is the focal point for addressing population, family development and reproductive health issues. LPPKN also plans, implements and coordinates programmes and activities, disseminates information and provides training for trainers. LPPKN's sexual and reproductive health (SRH) services were expanded in recent years via 49 clinics across the country. LPPKN collaborates with various government ministries and nongovernment organisations (NGOs) to deliver SRH programmes and services to the community.[3] PEKERTI was accepted and endorsed by all agencies related to sexual and reproductive health education (SRHE), including the Ministry of Education (MoE), the Ministry of Health (MoH).

It is a well-known and well-accepted fact that the perception and acceptance of sexuality education is significantly influenced by religious and cultural norms, especially among Muslim communities and countries. One manifestation of this is the reservation on the use of certain terms. It is in recognition of this that PEKERTI uses the term *social* instead of *sexual/sexuality* education.[4]

In 2009, PEKERTI was considered a National Policy - *Dasar Pendidikan Kesihatan Reproduktif dan Sosial.* In 2012, it became both a Policy and PoA. The 2009-2012 PEKERTI contains the SRHE Policy and the related PoA in one document. **Appendix 1** presents the salient features and content of PEKERTI. Any review or update can apply to either or to both components (policy and PoA). The request from LPPKN for the update applies to the PoA component.

There was no formal evaluation of PEKERTI between 2009 and 2012. Two evaluations were undertaken in 2017. The first evaluated the PEKERTI programmes supported by the United Nations Population Fund (UNFPA) in the Country Programme Action Plan 2013-17. The second was conducted by LPPKN and MWFCD and evaluated PEKERTI in entirety.

[3] Ministry of Women Family and Community Development, Lembaga Penduduk Dan Pembangunan Keluarga Negara
[4] The Malaysian government refers to SRH education as encompassing the 8 principles of UNESCO's 2018 International Technical Guidance on Sexuality Education outlined in **Figure 4**.

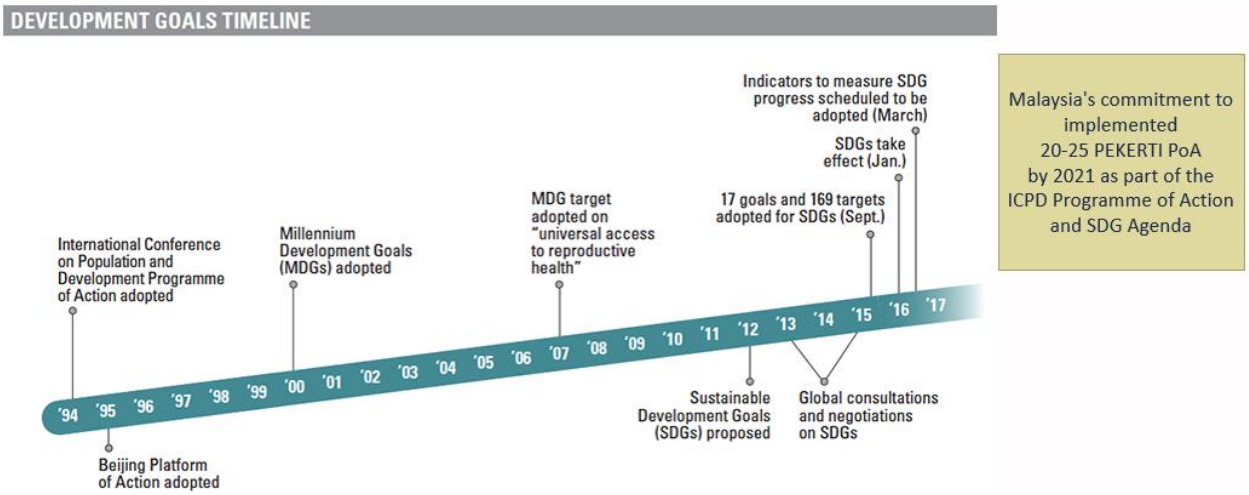
1.2 The need to review and update Malaysia's National Reproductive Health and Social Education

The 2017 LPPKN and MWFCD evaluation[5] recommended the urgent review of the 2009-2012 PEKERTI PoA, focusing on SRH rights and choices. To fulfill Malaysia's international commitments, PEKERTI needs to be informed by developments impacting on SRH education and services since 2012. In particular, the International Conference on Population and Development (ICPD) PoA and the Sustainable Development Goals (SDGs) together with developments in human capacity, new communication technologies, and changes in population dynamics and demographics. This review will support the fulfillment of Malaysia's commitment to implementing SRH education by 2021 as part of the ICPD PoA and the 2030 SDG Agenda (**Figure 1** and

[5] LPPKN & MWFCD (2017) Draft Evaluation Report of the Implementation of Reproductive and Social Health Policy and Plan of Action

Figure 2).[6] The new PEKERTI PoA will enhance the effectiveness of comprehensive and age-appropriate SRH education, commencing from age 5, in formal and informal settings.

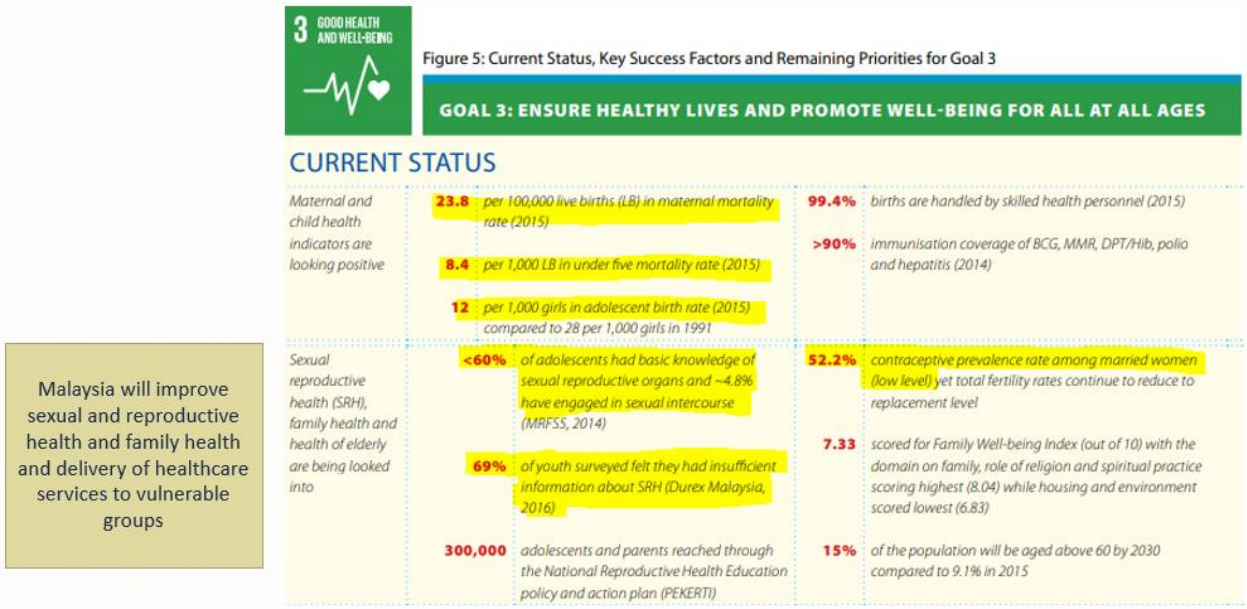
Figure 1 Sexual and Reproductive Health Education Sustainable Development Commitments [7]



[6] Malaysian Government (2019) Accelerating Malaysia's Progress Towards Implementation of ICPD Programme of Action. In: Nairobi Summit.

[7] Guttmacher Institute (2015) Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals. In: Guttmacher Institute.

Figure 2 Malaysia Sustainable Development Goals: 2017 Voluntary National Review [8]



1.3 Objectives of review

The objectives of the review are to:
(1) consider the evaluation findings of the 2009-12 PEKERTI Plan of Action[9] and other relevant sources of information;
(2) conduct a comprehensive review of SRHE across selected Muslim countries with a Sunni majority; and
(3) propose recommendations to improve the draft PEKERTI PoA.

1.4 Approach of review

In 2020, LPPKN requested support to review and update the PEKERTI PoA for 2020-24. UNFPA commissioned the United Nations University International Institute of Global Health (UNU-IIGH) to undertake this desk review to inform the update. UNU-IIFGH is both a United Nations organisation and a high-level research and teaching institution that aims to advance evidence-based policy on key issues related to sustainable development and global public health. It supports the United Nations' work by objectively translating evidence to policy with intellectual independence guaranteed by the UNU Charter.

LPPKN conducted a consultative process to provide additional information under the guidance of a Technical Working Committee (TWC) chaired by LPPKN's Deputy Director-General (Policy). The TWC was composed by key government and non-government stakeholders involved in SRH and SRHE (see **Appendix 2**). On 10-12 August 2020, LPPKN, as the lead and coordinating agency and the Secretariat to

[8] Economic Planning Unit (2017) Malaysia Sustainable Development Goals: Voluntary National Review
[9] LPPKN & MWFCD (2017) Draft Evaluation Report of the Implementation of Reproductive and Social Health Policy and Plan of Action

the Advisory and Coordinating Committee for Reproductive Health (ACCRH), conducted a Brainstorming Workshop with key stakeholders (including UNU-IIGH's lead researcher) to discuss a preliminary draft of 2020-24 PEKERTI PoA (**Appendix 6**). Workshop participants recommended that the Draft PoA should cover 2021-25 to align it with the 2021-25 Twelfth Malaysia Plan [10]. However, the *Draft National Reproductive and Social Health Education Plan of Action* developed by LPPKN in 2018-19 was agreed by the Policy Division (MWFCD) to cover the period 2020-24.

The desk review was intended to provide further input into the preliminary draft of the PEKERTI PoA. While the review's scope and focus are on SRHE, it also includes SRH services. SRHE is considered a component of the overall SRH services, as SRH knowledge and skills include awareness of available SRH services. International guidelines on CSE note its linkages to the broader SRH programmes and services as a core component. Since sociocultural and religious factors significantly influence the approach, content and implementation of SRH education, the review compares selected countries with Sunni Muslim majority demographics.

The desk review is based on relevant UNFPA guidelines and international frameworks, and sexuality education policies and PoAs of the selected Muslim countries that align with Malaysia's Islamic Sunni faith. Section 3 Methodology contains further details.

[10] Malaysian Government (2020) Twelfth Malaysia Plan, 2021-2025

2. CONCEPTUALISING SEXUALITY EDUCATION

2.1 The Evolution of Sexuality Education

Sexuality is a natural part of human development and a critical dimension of health. It is crucial for the development of identity, morality, and the capacity of intimacy. Initial sexual experiences with sexual partners (positive or negative) have a profound effect on physical, mental and social development and overall well-being by either promoting or impeding the ability to develop intimacy, an essential component of healthy sexual relationships.[11] SRH is a key objective of the health, education and gender equality Sustainable Development Goals (SDGs) (Goals 3, 4 and 5 respectively). Nations should move toward universal access to a wide range of sexuality education and services provided across the life course.[12] Relevant World Health Organization definitions are provided in **Box 1**.[13]

Box 1 Relevant World Health Organization definitions

- **Sexual health** is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.
- **Sex** refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean *sexual activity*, but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.
- **Sexuality** is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.
- **Sexual rights**: the fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws

Source: WHO (2017) Sexual health and its linkages to reproductive health: an operational approach

[11] Firestone R, Firestone LA, Catlett, J (2005) Sex and Love in Intimate Relationships
[12] ARROW (2019) Brief: Universal Health Coverage and Integrating SRHR. Asian-Pacific Resource & Resource Centre or Women
[13] WHO (2017) Sexual health and its linkages to reproductive health: an operational approach

While sexuality education should include a life course approach, governments often focus on children, adolescents and young people. However, sexual life continues to be important in later life as an expression of intimacy and affection. Sexual activity supports physical functioning in older adults and boost self-confidence. Available research indicates that sexual desire still exists in older men and women.[14] However, there is limited research examining the sexuality of older adults to inform sexuality education for this demographic group beyond sexual dysfunction assessments. [15]

The ICPD PoA, adopted by 179 member-states (including Malaysia), introduced a comprehensive definition of reproductive health and set out the right of men and women to be informed and have access to safe, effective, affordable and acceptable family planning methods of their choice.[16] These universal rights require the provision of sexuality education and services to all demographic groups regardless of their marital status. The 2012 UN Commission on Population and Development, which focused on adolescents and young people, reiterated these rights.[17] The International Planned Parenthood Federation (IPPF), a global service provider and a leading advocate of SRH and rights developed a *Charter on Sexual and Reproductive Health Rights*. This Charter notes the right to SRH as the enjoyment of *mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy,* and the ability to regulate one's *fertility without adverse consequences*. [18]

The comprehensiveness of SRHE can differ across the policies and programmes of different countries. In general, there are three approaches:

- A conservative **Abstinence Only Until Marriage (AOUM)** approach teaches adolescents that the only morally correct option is abstinence. It discourages pre-marital sexual relationships and censors information about contraception and condoms for prevention of STIs and unintended pregnancies.[19] AOUM programmes are scientifically and ethically problematic and have been rejected widely by medical and public health professionals. As many adolescents engage in premarital sex, abstinence intentions often failmand are not sustainable. AOUM programmes provide incomplete information and marginalise sexually active adolescents, sexual assault survivors, pregnant and caring adolescents, and those non-conforming to traditional gender roles.[20] Since AOUM usually withholds information about human sexuality and provides medically inaccurate and stigmatising information, it threatens fundamental human rights to

[14] Sathyanarayana Rao TS, Tandon A, Manohar S, Mathur S (2018) Clinical Practice Guidelines for management of Sexual Disorders in Elderly. Indian J Psychiatry 60:S397–S409.
[15] Macleod A, McCabe MP (2020) Defining sexuality in later life: A systematic review. Australasian Journal on Ageing 39:6–15
[16] UNFPA (2004) Programme of action: adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994.
[17] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[18] IPPF (2003) Charter on Sexual and Reproductive Rights Guidelines
[19] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press
[20] Santelli J, Grilo SA, Lindberg LD, et al (2017) Abstinence-only-until-marriage policies and programs: An updated position paper of the Society for Adolescent Health and Medicine. J Adolesc Health 61:400–403.

health, information and life.[21] Literature reviews and meta-analyses of school programmes reveal that AOUM interventions are unsuccessful in delaying sexual activity initiation, modifying unsafe sexual behaviors, (e.g. preventing unprotected sex) and reducing the incidence of STIs or unintended pregnancies.[22, 23]

- More progressive **Abstinence-Plus Education programmes** include information about contraception and condoms in the context of strong abstinence messages. These programmes acknowledge that many teenagers will become sexually active, so the curriculum includes information on contraceptive protection from STIs and unwanted pregnancy and abortion. This approach has protective effects for behavioural and biological outcomes, including delay of sexual initiation, reduction of sexual activity, and reduced incidence and frequency of unprotected sex. However, there is limited evidence on reducing pregnancy incidence and no conclusive evidence of impact on STI incidence.[24]
- The latest evidence supports the **Comprehensive Sexuality Education** (CSE) approach which aims to enhance adolescents' capacity for educated, safe and respectful sexual choices. While CSE primarily teaches abstinence as the best method for avoiding STIs and unintended pregnancy, it also provides age-appropriate information (commencing at five years of age) on contraception and condoms to reduce risks. It incorporates interpersonal and communication skills and girls' empowerment components to support children, adolescents and young people's exploration of their own values, attitudes, believes, goals and options.[25] CSE is an effective intervention for generating HIV-related knowledge and decreasing sexually risky behaviors (delaying sexual debut, increasing condom use, and decreasing sexual partners).[26] CSE is increasingly internationally recognised as the most effective structural approach to optimise adolescents' physical and reproductive well-being.

Table 1 summarises the findings from several recent systematic reviews and meta-analyses assessing CSE's impact across cultures.

[21] Santelli J, Grilo SA, Lindberg LD, et al (2017) Abstinence-only-until-marriage policies and programs: An updated position paper of the Society for Adolescent Health and Medicine. J Adolesc Health 61:400–403.
[22] Silva M (2002) The effectiveness of school-based sex education programs in the promotion of abstinent behavior: a meta-analysis. Health Educ Res 17:471–481.
[23] Trenholm C, Devaney B, Fortson K, et al (2007) Impacts of Four Title V, Section 510 Abstinence Education Programs. Final Report. Mathematica Policy Research, Inc
[24] Underhill K, Operario D, Montgomery P (2007) Systematic Review of Abstinence-Plus HIV Prevention Programs in High-Income Countries. PLOS Medicine 4:e275.
[25] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press
[26] Fonner VA, Armstrong KS, Kennedy CE, et al (2014) School based sex education and HIV prevention in low- and middle-income countries: a systematic review and meta-analysis. PLoS ONE 9:e89692.

Table 1 Summary findings from systematic reviews assessing the impact of CSE programmes across countries

Study type	Findings
A 2018 systematic review of 66 reviews reporting on SRH outcomes published in 2005-15 focusing on young people (aged 10-24 years) [27]	• There is marked consistency of features improving SRH program effectiveness for young people despite the wide variation in interventions reviewed. • Common features of effective interventions included: longer-term or repeated implementation; multi-setting and multi-component; parental involvement; culturally/gender/age-appropriate; and skills-building.
A 2014 systematic review and meta-analysis of 64 studies in Low and Middle-Income Countries (LMICs) [28]	• School-based CSE interventions adapted from effective programmes and those involving a range of school-based and community-based components had the largest impact on changing HIV-related behaviors. • No CSE intervention was found to increase risky sexual behavior, dispelling the misconception that promoting safe sex may encourage early sexual activity.
A Cochrane review of 53 RCTs that enrolled 105,368 adolescents: 18 studies randomised individuals, 32 randomised clusters (schools (20), classrooms (6), and communities/ neighbourhoods (6). Four trials were conducted in LMICs, and all others were conducted in high-income countries.[29]	• Results showed that multiple interventions (combination of educational and contraceptive interventions) lowered the rate of unintended pregnancy among adolescents. • Educational interventions significantly increased reported condom use at last sex in adolescents compared to controls who did not receive the intervention • A combination of educational and contraceptive-promoting interventions appears to reduce unintended pregnancy among adolescents
A 2016 review of 17 studies [30]	• School-based curriculum programmes on sex education and HIV could effectively transform young people's behaviour and increase knowledge of risky sexual activity-related problems.
A 2016 review of 10 large and well-designed randomised controlled trials (RCTs) testing school-based interventions (middle school or high school levels) [31]	• Interventions that addressed HIV/STIs and pregnancy were more effective in improving contraceptive use among adolescents than programmes focused on pregnancy prevention alone. • Teachers' training and monitoring adherence to the protocol supports consistent intervention implementation.
A 2015 evaluation of *The World Starts With Me,* an innovative CSE programme implemented in 11 LMICs in Africa and Asia[32]	• Two-thirds of rigorously evaluated CSE programmes (quasi-experimental evaluation design including pre- and post-tests among intervention and comparison groups) lead to reductions in one or more risky sexual behaviours. • The evaluations proved the programme's effectiveness across implementing countries in terms of relevant SRH knowledge, including pregnancy, positive attitudes towards contraception, self-efficacy (contraceptive use), and intentions such as delaying first intercourse and seeking sexual health services.

[27] Bowring AL, Wright CJC, Douglass C, et al (2018) Features of successful sexual health promotion programs for young people: findings from a review of systematic reviews. Health Promotion Journal of Australia 29:46–57.
[28] Fonner VA, Armstrong KS, Kennedy CE, et al (2014) School based sex education and HIV prevention in low- and middle-income countries: a systematic review and meta-analysis.
[29] Oringanje C, Meremikwu MM, Eko H, et al (2016) Interventions for preventing unintended pregnancies among adolescents. Cochrane Database of Systematic Reviews.
[30] Jnr LAD (2016) The Efficacy of HIV and Sex Education Interventions among Youths in Developing Countries: A Review. Public Health Research 6:1–17
[31] Lopez LM, Bernholc A, Chen M, Tolley EE (2016) School-based interventions for improving contraceptive use in adolescents. Cochrane Database Syst Rev CD012249.
[32] Vanwesenbeeck I, Westeneng J, Boer T de, et al (2016) Lessons Learned from a Decade Implementing Comprehensive Sexuality Education in Resource Poor Settings: The World Starts with Me. Sex Education.

Gender equality and human rights are core elements of more advanced CSE programmes aligned with international SRH agreements and guidelines as well as evidence from best practice. There is substantive evidence of programme effectiveness providing adherence to basic CSE principles in terms of content (a comprehensive curriculum, including gender and rights as core elements) and delivery (learner centeredness).[33] Improving female education opportunities is also an effective intervention for reducing teenage fertility, including improving child health outcomes, improving health and labor market participation. Female empowerment accelerates progress with the SDGs, particularly in countries experiencing higher gender inequalities, and if targeting disadvantaged demographic groups such as low income and rural setting populations where educational opportunities have the greatest impact in reducing teenage fertility.[34]

CSE should be linked to a range of adolescent friendly sexual and reproductive counselling and services, including contraception, maternal health and gender-based violence (GBV) services. UN treaties and agreements, such as the *Convention on the Elimination of Discrimination Against Women* (CEDAW), the *Convention on the Rights of the Child* (CRC), the *Beijing Platform for Action*, the Millennium Development Goals (MDGs) and the SDGs, underpin CSE and endorse the concepts of reproductive health, reproductive rights and sexual health.[35] CSE is universal and inclusive of all ages across the life course for both men and women including: people with disabilities; people with special needs; and marginalised and vulnerable groups.

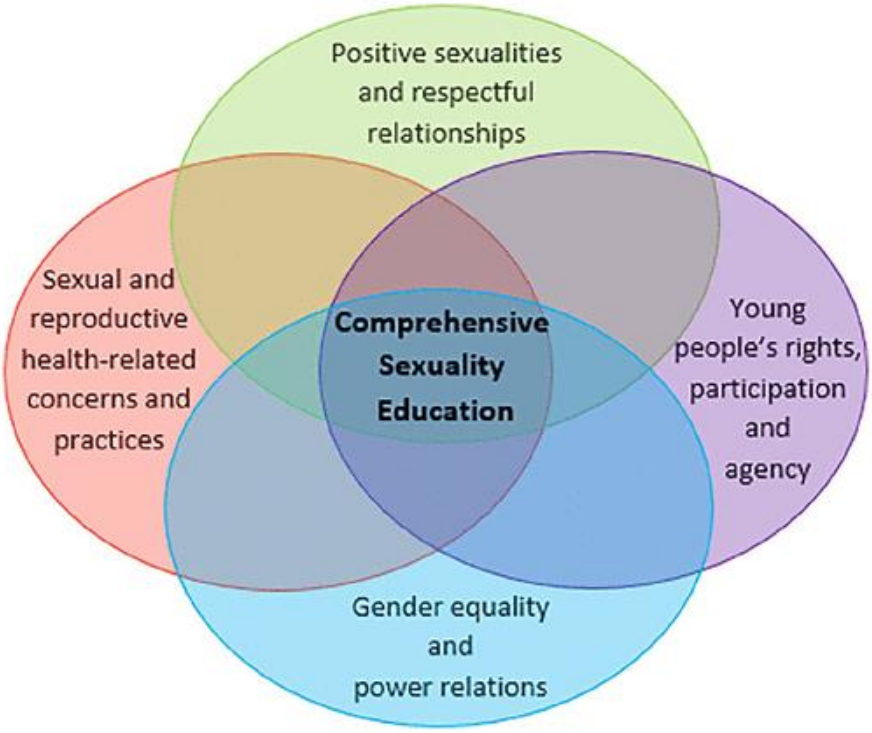
2.2 Comprehensive Sexuality Education curriculum content

An advanced CSE approach implies the adoption of a broad curriculum. International organisations documents identify core principles and essential CSE elements, including the 2010 IPPF Framework for Comprehensive Sexuality Education,[36] and WHO's Standards for sexuality education in Europe.[37] The 2014 UNFPA Operational Guidance for Comprehensive Sexuality Education[38] outlines several core principles in CSE programmes and curricula (**Section 3.3 – Table 2**). However, it is the 2018 UNESCO International Technical Guidance on Sexuality Education (ITGSE) that is the main guidance agreed to by six UN agencies, including WHO and UNFPA.[39]

[33] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press
[34] Güneş PM (2016) The Impact of Female Education on Teenage Fertility: Evidence from Turkey. The BE Journal of Economic Analysis & Policy 16:259–288.
[35] UNFPA (2004) Programme of action: adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994.
[36] International Planned Parenthood Federation (IPPF, 2010) Framework for Comprehensive Sexuality Education
[37] WHO Regional Office for Europe and BZgA. (2010). Standards for sexuality education in Europe: A framework for policy makers, education and health authorities and specialists. Cologne, BZgA.
[38] UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender
[39] UNESCO (2018) International Technical Guidance on Sexuality Education (ITGSE)

CSE's theoretical and normative elements are expanding and evolving in response to progressive insights and emerging evidence, as well as technical and social innovations. [40] Despite apparent absence of a common CSE definition, the core components are synthesised into four broad and interlinked themes that are given particular emphasis depending on the adapted approach undertaken: a) rights, participation and agency; b) sexual and reproductive health and behaviours; c) gender equality and power; and d) positive sexualities and respectful relations (**Figure *3***). [41]

Figure 3 Core components of Comprehensive Sexuality Education [42]



[40] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press

[41] Miedema E, Le Mat MLJ, Hague F (2020) But is it comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. Health Education Journal 0017896920915960.

[42] Figure extracted from Miedema E, Le Mat MLJ, Hague F (2020) But is it comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. Health Education Journal 0017896920915960.

2.3 Comprehensive Sexuality Education delivery principles

Schools are primary settings for implementing CSE. It might be delivered either as a stand-alone subject or integrated within other subjects, be mandatory or optional. Health centers and community-based settings also provide CSE opportunities, particularly for reaching vulnerable out-of-school adolescents and the broader community. CSE should be developmentally appropriate and preferably incremental, starting at an early age.[43] A quality CSE curriculum is more expansive than SRH and should cover contextual and relevant SRH issues. It requires teacher training for its implementation. It would involve the active participation of students in discussing issues. It should include referrals to appropriate available SRH services within an enabling environment/context at different levels (family, school, community, and political).[44] While no systematically and validated sexuality education training programmes exist for teachers and allied health professionals, sexuality education programmes should cover cultural and contextual knowledge, attitudes, values, and behaviours in adolescent sexuality. Teachers should be familiar with arguments for and against abstinence and CSE. More research is needed to examine the factors influencing teaching and learning processes and outcomes in sexuality education, such as how programmes, people, processes, policies, and places influence school-based education outcomes.[45]

UNESCO's ITGSE outlines eight concepts equally important and mutually reinforcing, and intended to be taught collectively with increasing complexity and considering age appropriateness (**Figure 4**).[46] National curriculum developers can interpret and make the learning objectives measurable based on the local situation and/or existing standards and frameworks as well as contextual needs (sociocultural norms and epidemiological context). While certain content might not be acceptable in some countries, each nation should ensure a human rights and non-discriminatory approach. Experts recommend teaching age-appropriate sexuality education as early and comprehensively as possible (preferably from age five).[47] WHO provides an overview of the components of competencies for educators delivering holistic sexuality education.[48] The competencies include a set of:

- *attitudes*: commitment to sexuality education, respect for integrity and understanding of boundaries and open-mindedness and respect for others;
- *skills*: the ability to create and maintain a safe, inclusive and enabling learning environment, to use interactive teaching and learning approaches, to communicate effectively, and to reflect on beliefs and values; and

[43] UNESCO (2018) International Technical Guidance on Sexuality Education
[44] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press
[45] Leung H, Shek DTL, Leung E, Shek EYW (2019) Development of Contextually-relevant Sexuality Education: Lessons from a Comprehensive Review of Adolescent Sexuality Education Across Cultures. International Journal of Environmental Research and Public Health 16:621.
[46] UNESCO (2018) International Technical Guidance on Sexuality Education (ITGSE)
[47] UNESCO (2018) International Technical Guidance on Sexuality Education (ITGSE)
[48] WHO Regional Office for Europe and BZgA. (2017). Training matters: A framework for core competencies of sexuality educators. Cologne: Federal Centre for Health Education (BZgA).

- *knowledge*: about relevant topics in sexuality education, health promotion and psychology, delivery methods of sexuality education, and different sexuality education approaches and their impact.

Figure 4 Overview of CSE's key concepts, topics and learning objectives [49]

Key concept 1: Relationships	Key concept 2: Values, Rights, Culture and Sexuality	Key concept 3: Understanding Gender
Topics: **1.1** Families **1.2** Friendship, Love and Romantic Relationships **1.3** Tolerance, Inclusion and Respect **1.4** Long-term Commitments and Parenting	Topics: **2.1** Values and Sexuality **2.2** Human Rights and Sexuality **2.3** Culture, Society and Sexuality	Topics: **3.1** The Social Construction of Gender and Gender Norms **3.2** Gender Equality, Stereotypes and Bias **3.3** Gender-based Violence

Key concept 4: Violence and Staying Safe	Key concept 5: Skills for Health and Well-being	Key concept 6: The Human Body and Development
Topics: **4.1** Violence **4.2** Consent, Privacy and Bodily Integrity **4.3** Safe use of Information and Communication Technologies (ICTs)	Topics: **5.1** Norms and Peer Influence on Sexual Behaviour **5.2** Decision-making **5.3** Communication, Refusal and Negotiation Skills **5.4** Media Literacy and Sexuality **5.5** Finding Help and Support	Topics: **6.1** Sexual and Reproductive Anatomy and Physiology **6.2** Reproduction **6.3** Puberty **6.4** Body Image

Key concept 7: Sexuality and Sexual Behaviour	Key concept 8: Sexual and Reproductive Health
Topics: **7.1** Sex, Sexuality and the Sexual Life Cycle **7.2** Sexual Behaviour and Sexual Response	Topics: **8.1** Pregnancy and Pregnancy Prevention **8.2** HIV and AIDS Stigma, Care, Treatment and Support **8.3** Understanding, Recognizing and Reducing the Risk of STIs, including HIV

[49] UNESCO (2018) International Technical Guidance on Sexuality Education (ITGSE)

2.4 Adapting the Comprehensive Sexuality Education approach

CSE requires awareness of cultural (ideological, religious, political) contexts and how they affect people's sexual choices, behaviors, and relationships. Different societies implement different sexuality education approaches. International surveys and reviews [50,51] note significant progress in CSE implementation in most developed countries. However, a gap remains between legal frameworks and the actual implementation; few policies are fully operationalised. In most LMICs, CSE is not yet institutionalised,[52] and there are many barriers to effective implementation.[53] The Global North primarily promotes CSE approaches while predominantly abstinence-only and abstinence-plus approaches are applied in the Global South[54] supported by the US and its foreign aid programmes such as President's Emergency Plan For AIDS Relief (PEPFAR).[55] Sexuality education content is also prioritised differently for adolescents. Sex-positive approaches, pleasure and personal wellbeing are emphasised in some European countries, while CSE initiatives for adolescents in the Global South are mainly driven by SRH related issues and attaining broader development goals.[56]

A 2019 cross cultural comparative review of adolescent sexuality education (US, UK, China, Hong Kong and Taiwan),[57] identified many gaps and inadequacies in sexuality education. The review noted that different policies are implemented in different societies. There islimited evidence-based sexuality education programmes, including evaluations, particularly in the Asian context, and a lack of evidence-based policies. The review considered that it is necessary to foster multi-disciplinary collaboration where students and parents, as key stakeholders, should be invited to co-design school-based sexuality education policy and programmes, along with teachers, youth workers, counselors, health care workers and religious leaders.

[50] WHO Regional Office for Europe and BZgA. (2017). Training matters: A framework for core competencies of sexuality educators. Cologne: Federal Centre for Health Education (BZgA).
[51] UNESCO (2015) Emerging evidence, lessons and practice in comprehensive sexuality education: a global review
[52] Haberland, N. A. (2015). The case for addressing gender and power in sexuality and HIV education: A comprehensive review of evaluation studies. International Perspectives on Sexual and Reproductive Health, 41(1).
[53] UNESCO (2015) Emerging evidence, lessons and practice in comprehensive sexuality education: a global review
[54] Miedema E, Le Mat MLJ, Hague F (2020) But is it comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. Health Education Journal 0017896920915960.
[55] Leung H, Shek DTL, Leung E, Shek EYW (2019) Development of Contextually-relevant Sexuality Education: Lessons from a Comprehensive Review of Adolescent Sexuality Education Across Cultures. International Journal of Environmental Research and Public Health 16:621.
[56] Miedema E, Le Mat MLJ, Hague F (2020) But is it comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. Health Education Journal 0017896920915960.
[57] Leung H, Shek DTL, Leung E, Shek EYW (2019) Development of Contextually-relevant Sexuality Education: Lessons from a Comprehensive Review of Adolescent Sexuality Education Across Cultures. International Journal of Environmental Research and Public Health 16:621.

An essential underpinning of CSE is behavioural change. Behavioural change theory calls attention to health behaviour determinants, including social values and skills, attitudes, and relationships. For CSE to be culturally relevant and address local needs, the determinants need to be identified. Researchers suggest the behavioural goals, their determinants and strategies are identified via a logic-model or by intervention mapping, a protocol for developing effective behavioural change interventions.[58]

UNESCO's ITGSE was developed in global consultation and was limited in terms of sexual rights to gain consensus. The CSE guidelines should be adapted to *what can reasonably be expected* in particular socio-cultural contexts and religious sensitivities.[59] *The World Starts With Me* programme has adapted CSE to a wide range of socio-cultural contexts (**Box 2**).

Box 2 Lessons learned from a decade of implementing a CSE programme: *The World Starts With Me*

The World Starts With Me is an innovative, computer-based, CSE programme that uses a rights- and evidence-based approach and is available on CD-ROM, the Internet and in print. The programme targets in- and out-of-school youth aged 12-19 years and combines education on SRHR with building IT skills and creative expression. It aims to empower young people to make responsible choices concerning relationships, sexuality and sexual and reproductive health by increasing their knowledge and self-esteem, developing their attitudes and enhancing their skills. It uses learner-centred and rights-based approaches, actively engaging youth in the programme's development and implementation. Teachers facilitate the empowerment process rather than teach content by not only aiming for behavioural change but also cognitive and social transformation. The didactic vision is aligned with current educational strategies such as outcomes-based learning and competency-based education.

The programme was originally developed with and for secondary school students in Uganda in 2003, guided by experts on sexuality and SRHR (known as Rutgers), Butterfly Works, SchoolNet Uganda and in partnership with teachers and students of the pilot schools. The programme has been adapted to different socio-cultural contexts and is being implemented in 11 LMICs in Africa and Asia, including Kenya (in 2005), Indonesia, Indonesian Papua, Thailand, Vietnam, Pakistan and Ethiopia (in 2007). Ghana, Malawi, Bangladesh and Burundi and planned for Zambia and Maasai youth in Kenya (in 2015). In 2015, about half of the countries involved were piloting the programme, and ranged from 400 teachers trained and 58,000 pupils reached in Kenya to 200 teachers trained and 16,500 pupils reached in Indonesia, 35 teachers trained and 1,250 pupils reached in Ghana and 4 teachers trained and 60 pupils reached in Bangladesh.

While the programme is generally implemented in secondary schools, adapted versions have been developed for settings such as primary schools, teacher trainings, health care settings working with young people born and living with HIV, young people's prisons and schools for young people with hearing and visual impairments. While most schools use the electronic version, limited resources in some schools (Uganda and Ghana) are using the paper version. A 2015 review presented the results of rigorous evaluations which proved the effectiveness of the programme across implementing countries in terms of relevant SRH knowledge including pregnancy, positive attitudes towards contraception, self-efficacy (contraceptive use) and intentions such as delaying first intercourse and seeking sexual health services. In 2010, the programme was recognised in UNESCO's International Technical Guidance for Sexuality Education as a model for CSE programmes.

Source: Vanwesenbeeck I, Westeneng J, Boer T de, et al (2016) Lessons Learned from a Decade Implementing Comprehensive Sexuality Education in Resource Poor Settings: The World Starts with Me. Sex Education.

[58] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press

[59] Miedema E, Le Mat MLJ, Hague F (2020) But is it comprehensive? Unpacking the 'comprehensive' in comprehensive sexuality education. Health Education Journal 0017896920915960.

2.5. Considerations for adapting Comprehensive Sexuality Education in Muslim countries

This section is relevant to Muslim countries who adopted the ICPD PoA and the 2012 UN Commission on Population and Development (focus on young people), with reservations in implementing the recommendations within the Islamic Law framework. The ICPD PoA and other agreements state that individual countries have the sovereign right to contextualise policies and programmes to conform to customary laws, values, and cultures. However, interventions should uphold individual rights and respond to adolescents' complex needs during physical, cognitive, emotional, social and moral development. [60]

The Holy Quran addresses sexuality and sexual needs as a fundamental part of our human identity. While Western culture views sexuality and sexual needs as individual rights, the Islamic teachings view them as fundamentally bound to responsibility and social accountability.[61] Puberty is a period of increased guidance in Islam. General Islamic sex education for children focuses on ethics in controlling desires, respecting aurat (parts of the body that should be covered), worshiping to avoid external influence (media or peers), considering commandments related to puberty, and maintaining communication with parents. Parents and educators should provide age-appropriate guidance to children, so they understand sexuality based on Islamic values.[62] Adapting any CSE curriculum model in Muslim countries should consider the negative connotations that extramarital sex has in Islam. However, religious doctrine and scientific evidence should be non-conflicting sources for formulating a culturally sensitive and innovative programme.[63]

As previously noted, the term *social* instead of *sexual/sexuality* used in PEKERTI reflects the local cultural and religious reality. Understanding the local cultural and religious reality is also the rationale for comparing Muslim countries where the population is mainly adherents of the Sunni faith, though belonging to the different *madzhabs* or schools of Islamic thought.

[60] Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau

[61] Ihwani SS, Muhtar A, Musa N, et al (2017) An overview of sex education: comparison between Islam and Western perspectives. al-Qanatir: International Journal of Islamic Studies 8:43–51

[62] Desiningrum DR, H DI (2018) Sexual Education For Children With Islamic Psychological Approach. Proceeding Annual International Conference on Islam and Civilization 1:

[63] Horanieh N, Macdowall W, Wellings K (2020) Abstinence versus harm reduction approaches to sexual health education: views of key stakeholders in Saudi Arabia. Sex Education 20:425–440.

3. METHODOLOGY

Participants of the August 2020 Brainstorm Workshop discussed a preliminary draft of the updated PEKERTI PoA in parallel with consultative meetings with the TWC. The discussion and consultative meetings led to the methodology for the desk review: (1) data collection methods, (2) selection of comparative Muslim countries, and (3) use of two frameworks to guide the analysis of the findings.

3.1 Data collection

A combination of data collection methods was used to meet the study objectives, including a desk review of relevant documents and several stakeholder consultations.

- **Document review:** documents reviewed included national and international policy documents related to SRH; national data and population surveys and census reports; evidence from reports (government, development partners and multilateral agencies); annual reports; donor reports; strategic plans, independent studies and peer-reviewed journal articles including systematic reviews.
- **Consultative meetings**: UNU-IIGH presented the research proposal with an initial literature review, methodology, and work plan (detailing the scope of work, approach, timelines for consultations and deliverables) to LPPKN and UNFPA partners on 22 June 2020 and to the TWC on 8 July 2020. A Workshop with key stakeholders from related government and non-government agencies took place on 10-12 July 2020 to inform the draft PoA.

3.2 Selection of comparative Muslim countries

The selection of comparative Muslim countries was based on an objective criteria and input from the TWC. A list of countries that align with Malaysia's Sunni faith were initially proposed by LPPKN: Egypt, Jordan, Bangladesh, Indonesia and Pakistan. An objective selection criteria compared contraceptive prevalence indicators, commitments to key international conventions relevant to SRH and rights, family planning strategies and SRHE PoAs, the integration of family planning policies into health care programmes, Islamic leaders' support, and committed public budgets for family planning programmes. This selection process identified Bangladesh and Egypt as best candidates for further country comparisons, with the best contraceptive prevalence progress indicators. The selection criteria were presented to the TWC at the 8 July meeting. The TWC suggested including Morocco and Turkey as they are similar to Malaysia's human and economic development levels. The finally agreed comparative countries are Turkey, Morocco, Egypt, and Bangladesh.

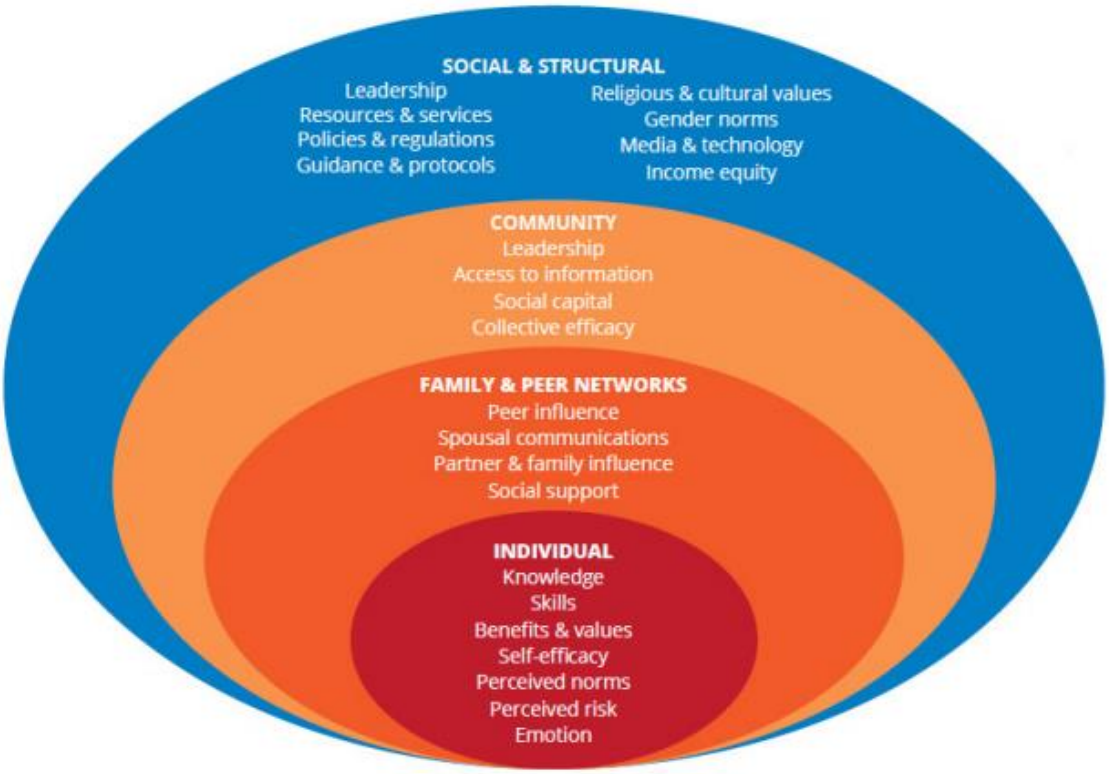
3.3 Frameworks guiding the analyses of selected Muslim countries

Two frameworks were used to conduct the desk review and comparative analysis; the socio-ecological framework and the UNFPA framework.

Socio-ecological framework

A comprehensive analysis of barriers and facilitators of CSE implementation within an adolescent's environment enables the design of strategies targeted to each level of influence and actively engages influencers to successfully reach adolescents and transform harmful social and gender norms. **Figure 5** shows that comprehensive and multilevel strategies are required to facilitate an enabling environment in which adolescents' rights are promoted, reinforced and practiced.[64] Simultaneous strategies might be implemented at the individual, family and peers, community, and social and structural environment levels.

Figure 5 Socio-ecological approach depicting levels of adolescents' influences [65]



[64] Chandra-Mouli V, Plesons M, Hadi S, et al (2018) Building Support for Adolescent Sexuality and Reproductive Health Education and Responding to Resistance in Conservative Contexts: Cases From Pakistan. Glob Health Sci Pract 6:128–136.
[65] USAID (2017) Guide for promoting sexual and reproductive health products and services for men.

UNPFA framework

UNFPA's 2014 CSE operational guidance[66] outlines the following core principles in CSE programmes and curricula: respect for human rights and diversity, with sexuality education affirmed as a right; critical thinking skills, promotion of young people's participation in decision-making, and strengthening of their capacities for citizenship; fostering of norms and attitudes that promote gender equality and inclusion; addressing vulnerabilities and exclusion; local ownership and cultural relevance; and a positive life-cycle approach to sexuality. This document outlines nine essential principles of how a CSE programme and related interventions are to be delivered, noted in
Table 2 with concepts expanded in **Box 3**.

Table 2 UNFPA's CSE essential principles and key intervention areas

9 essential principles of CSE programmes based on evidence.	**Key intervention areas**
1. A basis in the core universal values of *human rights*. UNFPA considers human rights to be a core component of, not an add-on to, CSE.	**Key intervention area 1:** *Strengthen policies and advocate for large-scale, sustainable sexuality education that is comprehensive* and reaches young people both in and out of school. This intervention includes five priority elements (refer to UNFPA's 2014 CSE guidelines for respective actions against priority elements): *Assess the policy environment; Ensure that managers and educators understand CSE; Provide leadership in advocating for and establishing large-scale CSE programmes, to be implemented in both formal and informal settings; Encourage CSE programmes to establish goals and objectives that align with ICPD PoA; and Build the evidence base to further inform policy debates and encourage investment.* **Key intervention area 2:** *Build technical capacity to strengthen programme quality, with a focus on CSE curricula, pedagogy and teacher training.* **Key intervention area 3:** *Enhance protective social factors*, beyond CSE curriculum and pedagogy, to encompass young people's learning and social environment. **Key intervention area 4**: Ensure that CSE programmes include *sound monitoring and evaluation components*, with due consideration to inequality, gender norms, power in intimate relationships, and intimate partner violence. This also involves ensuring a gender- and human rights-based approach to monitoring and evaluation of CSE which is the core of key intervention area 4.
2. *An integrated focus on gender*. Programmes should focus on gender in a number of ways. Gender may be a stand-alone topic within the CSE curriculum. Gender can be used to highlight the ways it influences puberty, sexuality, sexual and reproductive health, and HIV risk.	
3. Thorough and *scientifically accurate information*.	
4. *A safe and healthy learning environment*.	
5. *Linking to sexual and reproductive health services* and other initiatives that address gender, equality, empowerment, and access to education, social and economic assets for young people.	
6. *Participatory teaching methods* for personalization of information and strengthened skills in communication, decision-making and critical thinking.	
7. *Strengthening youth advocacy and civic engagement*.	
8. *Cultural relevance* in tackling human rights violations and gender inequality	
9. *Reaching across formal and informal sectors and across age groupings*.	

[1] During the pre-inception meeting on 22 June 2020, LPPKN stakeholders noted all the nine principles to be most urgent and doable, and most culturally and religiously acceptable in Malaysia's SRH education context.

[66] Extracted from UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

Box 3 Comprehensive Sexuality Education explained

CSE is an curriculum-based education providing children, adolescents and young people with the knowledge, skills, attitudes and values to develop a positive view of their sexuality, in the context of their emotional and social development, and proven effective in achieving positive sexual health outcomes, delaying early sexual activity and supporting academic achievement. CSE explores and nurtures positive values and attitudes towards SRH, and develops self-esteem, respect for human rights and gender equality. CSE empowers children, adolescents and young people to control their behaviour and treat others with respect, acceptance, tolerance and empathy, regardless of their gender, ethnicity, race or sexual orientation. CSE is a curriculum-based education which equips young people with the knowledge, skills, attitudes and values to develop a positive view of their sexuality, in the context of their emotional and social development. CSE is more effective at achieving positive sexual health outcomes, delaying early sexual activity, and supports academic achieve and other development goals.[1] CSE:

• **Provides accurate information about human sexuality, sexual and reproductive health, and human rights** (sexual anatomy and physiology; reproduction, contraception, pregnancy and childbirth; STIs and HIV/AIDS; family life and interpersonal relationships; culture and sexuality; human rights empowerment, nondiscrimination, equality and gender roles; sexual behaviour and sexual diversity; and sexual abuse, gender-based violence and harmful practices).

• **Explores and nurtures positive values and attitudes towards one's own SRH, and develops self-esteem, respect for human rights and gender equality**. CSE empowers young people to control their behaviour and treat others with respect, acceptance, tolerance and empathy, regardless of their gender, ethnicity, race or sexual orientation.

• **Develops life skills that encourage critical thinking, communication and negotiation, decision-making and assertiveness** leading to better relationships with family members, peers, friends, and romantic or sexual partners.

When CSE is started early, provided over time and involves all of the elements listed above, young people are more empowered to make informed decisions about their sexuality, including their SRH, and can develop the life skills necessary to protect themselves while respecting the rights of others.

Sexuality education might be referred to life skills, family life, HIV education or holistic sexuality education across settings. However, the core principles identified in the *2010 Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health* should be withhold in sexuality education programmes and curricula:

- Respect for human rights and diversity, with sexuality education affirmed as a right
- Critical thinking skills, promotion of young people's participation in decision-making, and strengthening of their capacities for citizenship
- Fostering of norms and attitudes that promote gender equality and inclusion
- Addressing vulnerabilities and exclusion
- Local ownership and cultural relevance
- A positive life-cycle approach to sexuality

The four essential elements of the programme are: (1) to take a positive view of sexuality; (2) to support individual autonomy, responsibility and enjoyment; (3) to promote and achieve gender equality; and (4) to advance human rights. The programme also stresses the importance of participatory teaching methods to encourage critical thinking.

Source: Extracted from UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

4. FINDINGS ON SEXUAL AND REPRODUCTIVE HEALTH IN SELECTED COUNTRIES

While this desk review's focus is SRH education, the broader domain of SRH programmes and services were also included. The findings encompass two main areas: the SRH situation in the five countries and the socio-cultural, religious and legal frameworks related to SRH. The SRH situation in any country is underpinned by the wider socio-economic determinants of health and human development. Therefore, the latter is presented as a finding in this section, using selected human development indicators.

4.1 Human development indicators

The UN's Global Human Development Indicators were used to compare the relevant indicators across the reviewed countries (**Appendix 3**). In 2018, Malaysia had the smallest population, followed by Morocco, Turkey, Egypt and Bangladesh; it also had the highest life expectancy. About 75% of Malaysia's and Turkey's population live in cities, followed by Morocco, Egypt, and Bangladesh. Malaysia had the highest labour force participation and the least percentage of youth (ages 15-24) out of school or employment.

The *Human Development Index* (HDI) is a summary measure for assessing long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living. Malaysia's HDI value for 2018 was 0.804, ranking 61 out of 189 countries (**Table 3**), second only to Turkey (0.806, ranked 59), followed by Egypt (0.700, ranked 116 – high human development), Morocco (0.676, ranked 121 – medium human development) and Bangladesh (0.614, ranked 135 – medium human development).[67] Malaysia made remarkable improvements in these indicators between 1990 and 2018, increasing its HDI 24.9%, from 0.644 to 0.804, Gross National Income (GNI) per capita by approximately 167.6%, life expectancy by 5.1 years, mean years of schooling by 3.6 years, and expected years of schooling by 3.7 years.[68]

Table 3 2018 Human Development Indicators for selected countries[69]

	HDI value			HDI Rank	Life expectancy			Expected years of schooling			Mean years of schooling			Gross National Income (GNI) per capita (2011 PPP USD)		
	All	F	M		All	F	M	All	F	M	All	F	M	All	F	M
Turkey	0.806	0.771	0.834	59	77.4	80.3	74.4	16.4	15.9	16.9	7.7	6.9	8.4	24,905	15,920	34,138
Malaysia	0.804	0.792	0.815	61	76	78.2	74.1	13.5	13.8	13.1	10.2	10	10.3	27,227	20,820	33,279
Egypt	0.700	0.643	0.732	116	71.8	74.2	69.6	13.1	13.1	13.1	7.3	6.7	8.0	10,744	4,364	16,989
Morocco	0.676	0.603	0.724	121	76.5	77.7	75.2	13.1	12.6	13.6	5.5	4.6	6.4	7,480	3,012	12,019
Bangladesh	0.614	0.575	0.642	135	72.3	74.3	70.6	11.2	11.6	10.8	6.1	5.3	6.8	4,057	2,373	5,701

The *Gender Development Index* (GDI) was introduced in 2014 and ranks 166 countries based on the sex disaggregated HDI, defined as a ratio of female to male HDI. GDI measures gender inequalities in

[67] UN Human Development Programme (2020) Global Human Development Indicators.
[68] Human Development report (2019) Malaysian Briefing note
[69] UN Human Development Programme (2020) Global Human Development Indicators.

achievement in three basic dimensions of human development: health (measured by female and male life expectancy at birth), education (measured by female and male expected years of schooling for children and mean years for adults aged 25 years and older) and command over economic resources (measured by female and male estimated GNI per capita.[70] In 2018, Malaysia had a female HDI value of 0.792 compared with 0.815 for males, resulting in a GDI value of 0.972, positioning it as medium-high gender equality, followed by Turkey (0.924, medium-low equality). In comparison, GDI values for Egypt (0.878), Morocco (0.833) and Bangladesh (0.833) qualify them as having low gender equality (

[70] Standard of living is measured by Gross National Income (GNI) per capita expressed in constant 2011 international dollars converted using purchasing power parity (PPP) conversion rates.

Table 4).[71]

The *Gender Inequality Index* (GII) was introduced in 2010 and ranks 162 on the loss in human development due to gender-based inequalities in three dimensions: reproductive health, empowerment, and economic activity, and ranges from 0 where women and men fare equally, to 1 where one gender fares as poorly as possible in all measured dimensions. Reproductive health is measured by maternal mortality and adolescent birth rates. Empowerment is measured by the share of parliamentary seats held by women, and attainment in secondary and higher education by each gender. Economic activity is measured by the labour market participation rate for women and men. [72]

Malaysia had a GII value of 0.274, ranking it 58 out of 162 countries in the 2018 index. In Malaysia, 15.8% of parliamentary seats were held by women, 79.8% of adult women reached at least a secondary education level compared to 81.8% of their male counterparts. For every 100,000 live births, 40 women died from pregnancy-related causes. The adolescent birth rate was 13.4 births per 1,000 women aged 15-19 in 2015, which improved to 9 births per 1,000 women by 2018.[73] Female participation in the labour market was 50.9% compared to 77.4% for men. Malaysia's GII ranking of 58 places it in a better position than the selected countries, with GII values ranking them as 66 for Turkey, 102 for Egypt, 118 for Morocco and 129 for Bangladesh (

[71] UN Human Development Programme (2019) Human Development Report Technical Notes.
[72] UN Human Development Programme (2019) Human Development Report Technical Notes.
[73] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains

Table 4).[74] In summary, Malaysia had the best gender indicators across the selected comparative Muslim countries.

[74] UN Human Development Programme (2020) Global Human Development Indicators.

Table 4 2018 Gender Development Index and Gender Inequality Index for selected countries[75]

	GDI value	GII	GII rank	Maternal mortality ratio	Adolescent birth rate	Female seats in parliament	% Population with at least some secondary education		Labour force participation	
							F	M	F	M
Malaysia	0.972	0.274	58	40.0	13.4	15.8	79.8	81.8	50.9	77.4
Turkey	0.924	0.305	66	16.0	26.6	17.4	44.3	66.0	33.5	72.6
Egypt	0.878	0.450	102	33.0	53.8	14.9	59.2	71.2	22.8	73.2
Morocco	0.833	0.432	118	121.0	31.0	18.4	29.0	35.6	21.4	70.4
Bangladesh	0.895	0.536	129	176.0	83.0	20.3	45.3	49.2	36.0	81.3

4.2 Sexual and reproductive health situation

There are well-known and commonly used SRH indicators to monitor progress in achieving the SDGs. This section presents several groups of indicators to describe the five countries' progress in maternal and child health, family planning, adolescent fertility rate, and STIs, particularly HIV/AIDS.

Maternal and child health

Malaysia and Turkey had: the highest antenatal care coverage with at least one visit at 97%, compared with 90% for Egypt, 77% for Morocco and 64% for Bangladesh; the highest percentage of births attended by skilled health personnel at 99.5%, compared to 98% for Turkey, 92% for Egypt, 87% for Morocco and 68% for Bangladesh; and the lowest infant mortality rate at 7.2 per 1,000 live births, compared with 10 for Turkey, 18.8 for Egypt, 20 for Morocco and 2.9 for Bangladesh, the lowest under 5 mortality rate at 8.8 per 100,000 live births, compared with 11.6 for Turkey, 22.1 for Egypt, 23.3 for Morocco and 32.4 for Bangladesh. Turkey had the lowest maternal mortality ratio at 16 deaths per 100,000 live births, compared with 22 for Malaysia, 33 for Egypt, 121 for Morocco and 176 for Bangladesh (**Appendix 3**.

Family planning

Both Malaysia and Turkey introduced contraceptive programmes a few decades ago, and this has effectively reduced the Total Fertility Rate (TFR) reaching replacement level in 2018 (2.0 births per couple); the lowest TFR across the reviewed countries. Thus, Malaysia and Turkey's population strategy shifted in recent years to encourage higher fertility, while Egypt and Bangladesh are still focusing on controlling the population growth (**Appendix 3**).

The prevalence of premarital sex is used as proxy to measure shifts in adolescents' attitudes toward sexual activity and inform provision of SRH education and services. The prevalence of premarital sex among Malaysians aged 12-24 years (as measured by local studies and national surveys during 2005-15) ranges from 1.3% to 12.6%,[76] depending on the survey instruments, sample sizes, age groups, study periods and settings. Age at first marriage is another proxy indicator for initiation of sexual activity. The

[75] UN Human Development Programme (2020) Global Human Development Indicators.
[76] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

mean age at first marriage among Malaysians has increased from 25.6 in 1970 to 28.6 years in 2010 for men and from 22.1 to 25.7 years for women.[77] The increasing gap between age of first sexual intercourse and age of first marriage suggests that many youths are sexually active before marriage, reflecting a shift from traditional values linked to cultural and religious beliefs, towards progressive attitudes to sexual relationships.

Despite contraception services being available for all youth and women at government clinics, Malaysia had the lowest contraceptive prevalence rate (CPR) (any method) at 52.2% in 2014 (stagnated since 1984) and (modern method) at 34.3%,[78] followed by Egypt at 58.5%, Bangladesh at 62.3%, Morocco at 70.8% and Turkey at 73.5%.[79] Malaysia also had the highest unmet need for family planning[80] at 19.6% in 2014[81] (decrease from 25% in 2004),[82] followed by the unmet need for contraception in Morocco at 13%, Egypt at 12.6%, Bangladesh at 12%, and Turkey at 5.9%.[83] Malaysian studies have noted that low CPR is partly attributed to the inadequate promotion of SRH services and inaccessibility to adolescents due to the fear of stigma and discrimination. [84]

The 2014 Malaysian Population and Family Survey revealed that 74.2% percent of ever-married women aged 15-49 years have ever used family planning methods. [85] It is important to consider that family planning indicators such as CPR[86] and unmet need for contraception mainly capture married women in predominantly Muslim countries. Any extramarital sexual activity is forbidden for Muslims under Islamic Law. Since most unmarried women do not want a baby, the unmet need is likely to be underestimated.[87]

The Malaysian Government is taking a pronatalist approach, and a further increase in contraceptive prevalence is likely to reduce the TFR. However, it is critical to promote contraception among vulnerable groups with high unmet needs. These groups include young people affected by socioeconomic disadvantage and those exhibiting high risk behaviours. It also includes women currently married or in a

[77] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[78] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[79] UN Human Development Programme (2020) Global Human Development Indicators.
[80] This refers to the number or percent of women currently married or in union who are fertile and desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method. The total number of women with an unmet need for family planning includes those with an unmet need for limiting (who desire no additional children), and those with an unmet need for spacing (who desire to postpone their next birth by a specified length of time). Source: MEASURE Evaluation (2020) Unmet need for family planning
[81] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[82] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[83] Unmet need: > 25% is considered very high; ≤ 5% is considered very low - Demand satisfied by modern methods: > 75% is considered high; ≤ 50 is considered very low. Source: UN Population Division 2016 World Contraceptive Use (pg. 4)
[84] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[85] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[86] MEASURE Evaluation (2020) Contraceptive prevalence rate (CPR). https://www.measureevaluation.org/prh/rh_indicators/family-planning/fp/cpr.
[87] Najimudeen M, Sachchithanantham K (2014) An insight into low contraceptive prevalence in Malaysia and its probable consequences. Int J Reprod Contracept Obstet Gynecol 2014; 3(3): 493-496 Volume No.3:493–496.

relationships who desire to either end or postpone childbearing, but who are not currently using a contraceptive method. [88]

Adolescent fertility rate and related issues

Bearing children out of marriage is strongly disapproved across Muslim countries. Unwanted adolescent pregnancies limit girls' and young women's educational and economic prospects and slows socio-economic development. [89]

Malaysia had the lowest adolescent fertility rate of 8.5 births per 1,000 women aged 15-19 years in 2018, compared with 26.6 for Turkey, 53.8 for Egypt, 31 for Morocco and 82 for Bangladesh. However, teenage pregnancy remains a significant health and socioeconomic concern in Malaysia, with over 19,000 teenage mothers giving birth between 2009 and 2011.[90] Births among unmarried adolescents and young girls are mostly unintended and lead to serious public health and socioeconomic consequences. Between 2010 and 2019, 1,010 babies were reported by the Royal Malaysian Police as abandoned. The babies were left in various settings, from mosques to waste grounds, bushes, drains and public toilets. Many cases remain unreported.[91] In 2018, 32,087 children aged 0-4 years were registered in childcare centers overseen by the Malaysian Department of Social Welfare.[92] Identified barriers to further reductions in adolescent fertility rate include the limited SRH education and contraceptive practices.[93] Promoting contraception along vulnerable demographic groups will likely prevent further socioeconomic costs such as maternal and infant mortality attributed to illegal and unsafe abortions, criminal baby abandonment/dumping practices and child welfare services for abandoned babies.

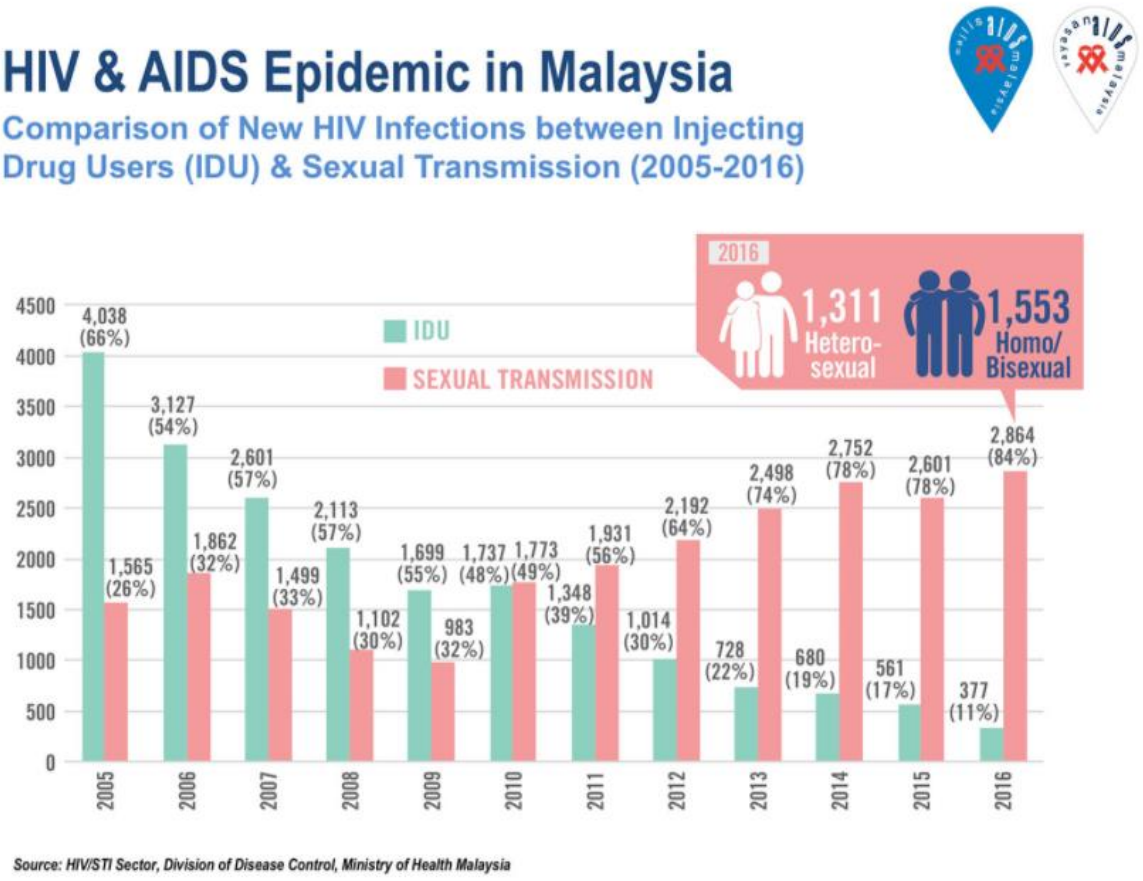
Sexuality transmissive infections, including HIV/AIDS

Unprotected sexual intercourse is associated with a high risk of STIs and other infections, including HIV/AIDS. Malaysia had the highest HIV prevalence among adults aged 15-49 years (0.4 compared with 0.1 for Egypt, Morocco and Bangladesh). While this could be because Malaysia is actively screening for HIV/AIDS cases, HIV/AIDS transmission in Malaysia has shifted from injecting drug users to sexual transmission in recent years (**Figure 6**).[94] There appears to be an upward trend towards high-risk sexual behaviours amongst young people in Malaysia. Reports revealed that 43% of all new 2017 HIV infections occurred among people aged 13-29 years (an increase from 40% in 2016), with 90% of young people acquiring HIV infection through unsafe sex (an increase from 84% in 2016).[95] Of the total reported HIV

[88] MEASURE Evaluation (2020) Unmet Need for Family Planning. https://www.measureevaluation.org/prh/rh_indicators/family-planning/fp/cpr.
[89] Guttmacher Institute (2015) Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals. In: Guttmacher Institute.
[90] Mohd MA, Adibah H, Haliza G (2015) A review of teenage pregnancy research in Malaysia. The Medical journal of Malaysia 70:214–219
[91] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[92] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[93] Federation of Reproductive Health Associations, Malaysia (2010) ICPD+15 3rd Country Report of Malaysia: NGO Perspectives
[94] Extracted from Malaysian AIDS Council (2016) HIV Statistics
[95] Ministry of Health (2018) Malaysia, Malaysia 2018: Country Progress Report on HIV/AIDS

infections between 1986 and 2016, 11% were females and 89% males, 69% were Malay followed by 15% Chinese and 8% Indians [96] However, these indicators might underestimate HIV incidence among youth, given the low uptake of STI clinic services by adolescents.[97] The chance of underestimation indicates the urgency for implementing SRH education if Malaysia is to reduce HIV prevalence among adults (ages 15-49) as part of achieving the SDG 3.3 target.[98]

Figure 6 HIV/AIDS Epidemic in Malaysia [99]



[96] Malaysian AIDS Council (2020) Overview of the HIV & AIDS Epidemic in Malaysia
[97] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[98] SDG 3.3 target: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. Source: UN development Programme (2019) Human Development Reports: HIV prevalence among adults.
[99] Extracted from Malaysian AIDS Council (2016) HIV Statistics

4.3 Legal and religious frameworks regarding sexual and reproductive health

This section provides information on the legal frameworks related to SRH to protect children, adolescents and young people. The legal frameworks include the legal age of marriage and legal instruments related to women and families, including abortion, sexual harassment and gender-based violence and female genital mutilation (FGM).

Children and young people

The Organisation of the Islamic Cooperation (OIC) issued an endorsement of the International Convention on the Rights of the Child (CRC) in Islam (**Box 4**). However, existing legal, political and institutional frameworks for adolescents' SRH rights do not guarantee access to accurate SRH information or education across the selected countries. Malaysia has several legal frameworks to protect children, including the *2001 Child Act* and the *2017 Sexual Offences Against Children Act*.

Box 4 The Covenant on the Rights of the Child in Islam

The *Covenant on the Rights of the Child in Islam*[1] issued by the Organisation of the Islamic Cooperation (OIC) representing 57 states (including Malaysia, Turkey, Morocco, Egypt and Bangladesh) states the following relevant articles:

- States Parties to the Covenant shall *guarantee the basics necessary for the survival and development of the child and for his/her protection from violence, abuse, exploitation and deterioration of his/her living conditions* (Art 6).
- The upbringing of the child should encourage him/her *to acquire skills and capabilities to face new situations and overcome negative customs, and to grow up grounded in scientific and objective reasoning* (Art 11)
- Regarding education, ***for the right of the child approaching puberty to receive proper sex education distinguishing between the lawful and unlawful*** (Art 11)
- *State parties shall take necessary measures to protect the child from all forms of abuse, particularly sexual abuse* (Art 7).
- States Parties to the Covenant, parents or legal guardians *shall* ***protect the child from practices and traditions which are socially or culturally detrimental or harmful to the health and from practices which have negative effects on his/her welfare, dignity or growth, as well as those leading to discrimination between children on basis of sex or other grounds*** *in accordance with the regulations and without prejudice to Islamic Shari'a* (Art 20).

Source: Organization of the Islamic Conference (OIC) (2005) Covenant on the Rights of the Child in Islam.

Minimum legal age of marriage

Child marriage is *a formal marriage or informal union before age 18 years*. It adversely affects girls and young women's health and limits their educational opportunities, and is associated with higher lifetime fertility, STIs and GBV.[100]

The law sets the legal minimum age of marriage at 18 years across the five countries. However, Islamic Law grants exceptions; a girl can marry once she reaches puberty. Child marriage is still practiced, particularly in rural areas and in clandestine ceremonies. Child marriage reflects a gender inequality pattern that reinforces stereotypical roles for girls, limits their education, compromises their health, and

[100] UNICEF (2011) Child protection from violence, exploitation and abuse

exposes them to the risk of violence and poverty, particularly those from vulnerable demographic groups or low socio-economic status. [101]

The Malaysian government had made reservations to CEDAW articles regarding women's rights to marriage and family relations, including child marriage.[102] In Malaysia, the *Islamic Family Law (Federal Territory) Act 1984* sets the minimum age of marriage at 16 years for girls and 18 years for boys. UNICEF defines this as child marriage.[103] **Table 5** details the exceptions allowed under Islamic and also civil law.[104] Child marriage remains an underestimated concern in Malaysia,[105] and the MWFCD launched initiatives to address child and forced marriage. The number of child marriage cases among non-Muslim Malaysian women (aged 20-24 years old and married before 18 years) is decreasing slowly from 2,713 in 2016 to 2,496 in 2018. No data was reported for Muslim women in 2018. [106] The minimum age of marriage in Malaysia should align with international standards and be 18 years for all legal frameworks, including civil, Muslim and native customary laws, without exceptions.[107]

Table 5 The legal minimum age of marriage across legal systems in Malaysia[108]

Legal System	Minimum Age for Marriage (years)		Exception	
	Male	Female	Male	Female
Islamic Law	18 (Section 8 IFLA).	16 (Section 8 IFLA).	Sharia Courts may grant its written permission under certain circumstances. (Section 8 IFLA).	Sharia Courts may grant its written permission under certain circumstances. (Section 8 IFLA).
Civil Law	18 (parental consent required for those under 21) (Section 10 LRA).	18 (parental consent required for those under 21) (Section 10 LRA).	Nil.	The Chief Minister of various states may grant a licence to authorize the solemnisation of marriage for those between the ages of 16 and 18. (Section 10 LRA).
Customary Law	18 (Adat Iban 1993).	16 (Adat Iban 1993).	A parent or legal guardian may give their written consent for underage marriages. (Adat Iban 1993).	A parent or legal guardian may give their written consent for underage marriages. (Adat Iban 1993).

Women and families

The desk review identified efforts to address SRH issues across the selected countries. In Malaysia, civil laws apply to both Muslims and non-Muslims, whereas family (Syariah) law applies to Muslims only. Syariah law is applied in a religious (Syariah) Court and covers issues such as incest, marriage, divorce, the custody of children and the division of assets in the event of marital breakdown for Muslims.[109] The

[101] UNICEF (2020) Child Marriage in Turkey
[102] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.
[103] Child marriage is defined as a formal marriage or informal union before 18. UNICEF (2011) Child protection from violence, exploitation and abuse
[104] ARROW (2018) National Report: Malaysia – Child Marriage: Its Relationship with Religion, Culture and Patriarchy
[105] ARROW (2018) National Report: Malaysia – Child Marriage: Its Relationship with Religion, Culture and Patriarchy
[106] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[107] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?
[108] *Sources: Islamic Family Law Act (IFLA), Law Reform Act (LRA) and Adat Iban.* Table extracted from ARROW (2018) National Report: Malaysia – Child Marriage: Its Relationship with Religion, Culture and Patriarchy
[109] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

protection of women is Item 1 on the Concurrent List in the Malaysian Constitution's Ninth Schedule. MWFCD is proposing the *Family Development on Gender Equality Bill*, in line with Malaysia's commitment to CEDAW. A proposal within the Bill is the establishment of a Gender Equality Commission.[110]

The Turkish Civil Code banned polygamy and granted women equal rights in matters of divorce, child custody, and inheritance. Although legal reforms have prohibited practices such as early and forced marriages, polygamy, and honor crimes since the 1920s, some Kurdish women who are unable to access education and cannot speak Turkish are unlikely to benefit from these laws.[111] The 2004 Penal Code (No 5237) in Turkey responded to intense civil society demands and removed references to traditional concepts such as morality, chastity, honor, and virginity. It criminalised customary killings and marital rape, and prohibited genital examinations (virginity control) performed without consent except when requested by the court as part of a criminal investigation.[112]

Women's empowerment remains a challenge in Morocco despite the progressive 2004 Family Code *Moudawana* that secured important rights for women. The rights included divorce by mutual consent, the right to child custody, responsibility for the family jointly shared by the husband and the wife and polygamy requiring a judge's authorisation, and the man's first wife's consent.[113] Substantial legalised gender discrimination persists, with women having fewer rights to economic assets (inheritance), social security benefits and marital property. The law is unequally applied, with public services dedicated to supporting women with legal matters remaining under the influence of social norms.[114] The Moroccan Parliament introduced a 30% gender quota in the 2011 budget to implement the *2011-20 National Reproductive Health Strategy*.[115]

Abortion

Malaysian Laws provide an exception to the prohibition of abortion in section 312 of the *Penal Code 1936*, as amended by the *1989 Penal Code Amendment Act* 574, and revised in 1997. A medical practitioner can legally perform abortions if the pregnancy's continuation would pose a greater risk to the woman's physical and/or psychological health than termination of the pregnancy. Under Syariah Law (Fatwa issued by the *26th Muzakarah of the National Fatwa Committee 1990*), abortion is allowed if the fetus is under 120 days of gestation and the mother's life is under threat or if the fetus is abnormal. Girls under 18 years require parental consent. [116]

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[110] Musa N, Husin A (2018) Towards gender equality in Malaysia: legal and policy perspectives. In: ResearchGate.
[111] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[112] Acar F, Altunok G (2013) The 'politics of intimate' at the intersection of neo-liberalism and neo-conservatism in contemporary Turkey. Women's Studies International Forum 41:14–23. https://doi.org/10.1016/j.wsif.2012.10.001
[113] Abdesslam B (2011) Social determinants of reproductive health in Morocco. African Journal of Reproductive Health 15
[114] World Bank Group (2018) Morocco: governing towards efficiency, equity, education and endurance; a systematic country diagnostic.
[115] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020
[116] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

Countries with restrictive abortion laws tend to manage unwanted pregnancies via primary and tertiary prevention only. Primary prevention is the provision of contraceptives, which may fail and which may not be universally available. Tertiary prevention is concerned with managing the complications of unsafe abortions and other post-abortion care. Secondary prevention, the provision of safe abortion services, is generally not available. Malaysia provides all three levels of prevention. The MoH released the *Guidelines for Termination of Pregnancy* in 2012, which set out safe abortion services standards.

In Turkey, the *Population Planning Law 1983* legalises abortion up to 10 weeks' gestation. However, there is political opposition to abortion, resulting in an unmet need for safe abortion services. In 2012, the government unsuccessfully proposed restricting access to safe abortion services. Nevertheless, women have reported difficulties in accessing abortion services across Turkey since 2012.[117] Public health institutions performed only 20% of abortions, and private practices and private hospitals permorme over half of abortions. [118]

Morocco amended its Penal code to legalise abortion in cases of incest, rape and fetal malformation, and maternal health risks.[119] The Egyptian *Penal Code of 1937* (sections 260-264) prohibits abortion under all circumstances.

Given the stigma associated with abortion, particularly in Muslim countries, many unmarried girls and young women may illegally terminate their pregnancies. Illegal termination will result in the underestimation of abortion rates where they are collected and reported.

Sexual harassment and gender-based violence

The Malaysian Government expected to introduce the Sexual Harassment Bill into Parliament in 2020. The Government has also drafted an Anti-Discrimination Against Women Bill to address gender equality pursuant to Article 8 of the Federal Constitution.[120] In 2012, Turkey adopted Law No. 6284 on the *Prevention of Violence against Women and the Protection of the Family*. Three main policy documents are being drafted: the *2018-23 Women Empowerment Strategy Document and Action Plan*; the *2016-20 Combating Domestic Violence against Women National Action Plan* and the *Early and Forced Marriage*.[121] In Morocco, the *2018 Hakkaoui Law* criminalises violence against women and imposes tougher penalties on perpetrators of violence in the private and public spheres, including sexual harassment, rape and domestic abuse (online and offline), and bans forced marriage. Morocco repealed the rape marriage law, which allowed a rapist to evade punishment by marrying his victim.[122] In 2014,

[117] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.
[118] Mihciokur S, Akin A, Dogan BG, & Ozvaris SB (2014) The unmet need for safe abortion in Turkey: a role for medical abortion and training of medical students, Reproductive Health Matters, 22:sup44, 26-35
[119] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[120] Malaysian Government (2019) Accelerating Malaysia's Progress Towards Implementation of ICPD Programme of Action. In: Nairobi Summit.
[121] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[122] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries

Egypt introduced an article addressing sexual harassment for the first time. Egypt is committed to a woman's right to be free from GBV, although the general community still holds conservative views.[123]

4.4 Sexual and reproductive health services

UNFPA's 2014 CSE operational guidance[124] considers SRH education linkage to SRH services as one of the core evidence-based CSE principles (**Table 2**). Therefore, this review covers the SRH services across the selected Muslim countries that contribute to achieving the health, education and gender equality SDGs (goals 3, 4 and 5 respectively). The international consensus is that the primary health care system should deliver SRH information and services linked to a range of adolescent friendly sexual and reproductive counselling and services, including contraception, maternal health and GBV services.[125] The ICPD urged governments to make reproductive health services available, accessible, acceptable and affordable to young people.[126] The Conference noted that existing health facilities, educational segments, and other social programmes largely ignored young people's reproductive health needs. Addressing these health needs could improve economic prosperity across all sectors and accelerate community development. [127] This section provides information on SRH programmes and services in the selected countries with the most comprehensive information for Malaysia.

Malaysia

Malaysia provides SRH services with relevant action plans that include all ages, genders, and marital status. The MoH mainly provides SRH information and services in partnership with LPPKN and the Federation of Reproductive Health Associations Malaysia (FRHAM) via clinics offering multidisciplinary services. The MoE, NGOs and the private sector also provide these services. **Table 6** details the Malaysian healthcare system method for procuring and delivering SRH information and services.[128] The *2001 Adolescent Health Policy* launch strengthened adolescent SRH services and public healthcare facilities began providing contraceptive and other SRH services to young people, regardless of their marital status.[129] The 2009-12 PEKERTI Policy directed Malaysia's efforts to increasing access to SRH information and services for young people, stressing positive values and responsible behaviour. [130] Since 1996, Malaysia has been providing universal access to SRH services for all adolescents in primary, secondary and tertiary healthcare facilities nationally. In recent years, the MoH has led initiatives to promote SRH services for both married and unmarried adolescents, as demonstrated by the MoH's *2012 Guidelines for Managing Adolescents Sexual and Reproductive Health problems at Health Clinics* to support adolescent-friendly health services. However, its implementation depends largely on healthcare providers.

[123] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[124] UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender
[125] WHO (2017) Sexual health and its linkages to reproductive health: an operational approach
[126] WHO (2017) Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation
[127] UNFPA (2014) Adolescent sexual and reproductive health
[128] Table extracted from Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[129] Ministry of Health Malaysia (2015) National Adolescent Health Plan of Action
[130] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia

SRH services in Malaysia were historically targeted to married couples. More recently, they are available to all demographic groups, though generally excluding abortion services which are more restricted.[131] Despite the availability of SRH services, unmet needs for contraceptive methods remains high, as SRH services are not adequately promoted, particularly among adolescents and young people. Stigma and discrimination also play a role in the lack of access to SRH services by adolescents and young people.[132] Unmet needs for SRH information and access to contraceptives should be urgently addressed to prevent further STIs and unintended pregnancies. [133] Health care providers should be trained to deliver SRH information and services in a confidential, non-judgmental and non-discriminatory manner.

SRH information and services often neglect older people. A 2016 Malaysian study commissioned by UNFPA to inform evidence-based recommendations for addressing the SRH of older persons noted the lack of an explicit public SRH programme and services for the elderly. Programmes focused primarily on sexual and intimacy behaviours, sexual dysfunction, and other problems. The existing SRH programs are not specifically designed for older people. NGOs dealing with ageing issues such as the National Council of Senior Citizens Organisations Malaysia and the Malaysian Healthy Ageing Society only focused on advocacy work and educational programmes, and excluded SRH related services. The lack of SRH programme and services for older persons might be due to various factors, including limited research and data, inadequate training of health care providers, limited knowledge of sexuality matters, health issues and chronic disease risk factors among older people. Additional barriers might include cultural and religious beliefs, attitudes and stereotypes of SRH and ageing, limited information and awareness on SRH among the older population, physical or psychological limitations caused by other health or economic problems and loss of independence. The 2016 Malaysian study recommended including older demographics within the PEKERTI PoA by strengthening SRH programmes and services for older persons, increasing multisectoral commitment and planning, and building service providers' capacity in SRH education, monitoring and evaluation, along with allocated financial resources and personnel.[134]

[131] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[132] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[133] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[134] Huang Soo Lee M, Lim L (2016) Evidence based approach in addressing the sexual and reproductive health (SRH) of older persons in Malaysia

Table 6 Sexual and reproductive health services in the Malaysian healthcare system.[135]

	Ministry of Health (MoH)[1]	Complementary to MoH	
Types of facility	**1. Static facilities: Hospitals, Health Clinics, MCH Clinics, Community Clinics 2. Outreach services: school health team, mobile health team**	**LPPKN: semi-government Kafe@Teen**	**FRHAM: Non-governmental organization**
Service provider	Multidisciplinary team: doctors, nurses, paramedics, allied health personnel Referral to other agencies and specialties as required: e.g. social welfare officer, school counsellor	Teen educators, counselors, nurses, nutrition consultants and medical officers	Peer educators, medical officers
Target group	All ages, including people with disabilities and unmarried	Adolescents and young people aged 13-24 years and their parents	All ages: drug users, sex workers, transsexuals, MSM (men who have sex with men) and disabled youth.
SRH information and treatment	MoH provides SRH education as well as service provision. SRH information, screening for nutrition problems, thalassemia and mental health status, counselling and referral. MCH: family planning services, perinatal services and intrapartum care (including unmarried teen pregnancy), cervical and breast cancer screening, STI and HIV prevention, screening and management, child abuse and domestic violence and HPV vaccination.	SRH information Reproductive clinic Contraception, pregnancy testing, subfertility treatment, Pap smear, andrology services, STI screening and treatment, breast cancer screening, HPV vaccination, general medical check-up, blood tests, counselling	The main focus is family planning. SRH information, contraceptive services including emergency contraception, antenatal services, pre and post counselling for HIV, HIV testing, pre- and post-abortion counselling, referral for abortion.
Available modules	Various modules/manuals/guidelines for each service available. Examples include: • 2012 Live Life, Stay Safe training module on RH for children, adolescent with disabilities • 2013 Perinatal Care Manual 3rd edition • 2009 Module Engaging Adolescent Using HEADSS Framework • 2012 Guidelines for Handling Adolescent Sexual and Reproductive Health Problems at Health Clinics • 2015 HIV/AIDS prevention *Healthy Adolescent*	"I am in control" modules (adolescent and parent versions), RHAM (Reproductive Health of Adolescent module), PEKERTI (teen pregnancy prevention)	• RHAM (in collaboration with NPFDB) • Peer educator programme • Contraception (i.e. choose2protect)
Location and operation time	Schools (scheduled timetable), health clinic (appointment based), Community Health Camps. Specific times and days: 8 am-5 pm every day except weekends Hospital services: 24 hours for emergency cases Health clinics: office hours	Kafe@teen at NPFDB or UTC, residential area, school, LPPKN camp. Kafe@teen: 8 am-5 pm Kafe@teen (UTC): 8 am-10 pm including weekends	Schools, universities, Kafe@teen Varies depending on the sponsor

Source: websites of MoH, NPFDB and FRHAM

[1] Information provided by the MoH representative within the Technical Working Committee (TWC).

[135] Table extracted from Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.

A 2019 review of Malaysia's progress regarding CEDAW noted that despite some positive changes in law and policy, there had been no significant shift in women's status regarding exercising their reproductive rights regarding the time and spacing of childbearing.[136] Many women experience barriers to accessing high-quality reproductive health services. For example, a husband's consent is required for sterilisation procedures. Despite the Civil and Syariah Laws allowing abortion to protect the physical and mental health of the mother, it is stigmatised and costly, and where government hospitals provide the service, information and counselling is delivered within from a religious perspective, rather than a right-based SRH approach. Access to reproductive healthcare is also limited for some groups of women, including refugee women, indigenous women, migrant women, transgender women, and female prisoners.

Turkey

Turkey has made marked progress in family planning to date.[137] However, access to SRH services has become more limited in the last five years due to the conservative political environment. The government has also endorsed pronatalist population planning to encourage women to bear a minimum of three children. Abortion is only one of the reproductive health services targeted. Advocacy to prioritise reproductive health services, and abortion care in particular, in the public health system are needed. [138]

Egypt

Egyptian young people enrolled in schools are covered by the School Health Insurance System which excludes RSH services and counselling. The Egyptian Family Planning Association is a lead Egyptian Government partner in the National Population Commission's ongoing initiative to increase contraceptive prevalence. The Association provides information, education and communication (IEC) programmes for the general public, many of which (particularly amongst young people) are run on a peer-to-peer basis. Emergency intervention to prevent reported early marriage is a key priority.[139] A 2013 Egyptian study assessing youth-friendly clinics noted an improvement in the overall environment for SRH education and service provision in recent years. Pilot government and non-government youth-friendly clinics are established. However, their coverage and use remain limited, with most beneficiaries being married women, highlighting the need to address cultural and religious sensitivities. Government commitment is required to scale up pilot clinics into a national programme to improve young people's welfare.[140]

Morocco

The Moroccan public sector provides 28 Youth Healthcare Centers (YHCs) targeted to those aged 10-25 years. Other multidisciplinary services include general medicine practitioners, mental health services

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[137] Benezra B (2014) The Institutional History of Family Planning in Turkey. Contemporary Turkey at a Glance

[138] MacFarlane KA, O'Neil ML, Tekdemir D, et al (2016) Politics, policies, pronatalism, and practice: availability and accessibility of abortion and reproductive health services in Turkey. Reproductive Health Matters 24:62–70.

[139] IPPF (2016) Egyptian Family Planning Association

[140] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26

(counselling), and specialist healthcare practitioners (gynecology, ophthalmology, dentistry). YHCs will be linked with other activities of the Ministries of Youth, Sports and Education. A study is planned to assess young people's experiences and suggestions regarding YHCs.[141]

Family planning commitments in Morocco guarantee reproductive health rights to decide the number and spacing of children, consent to marriage, be free from sexual and GBV, and marriage equality.[142] The *2020-24 National Reproductive Health Strategy* has several strategic principles: institutional coordination and evaluation; increasing access to SRH services for targeted populations; integrate a monitoring and evaluation system; strengthening SRH partnerships and research. The focused areas include: adolescents' SRH, including STIs, physical and mental health; family planning; re-designing premarital consultation, maternal health; perinatal care; addressing violence towards women and children; uterine, cervical and breast cancer prevention; infertility treatment; and health issues related to menopause.[143]

Bangladesh

The Population Council's review of programmes in Bangladeshi[144] noted that the standard government health facilities SRH information package for adolescents includes: physical and mental changes during puberty; general and menstrual hygiene; early marriage and reproductive health; birth control, and violence against adolescent girls and boys. Most health facilities excluding Community Clinics have family planning commodities and equipment but only 40% can offer modern family planning services. [145] Despite the provision of youth-friendly services (**Box 5**), usage rates are yet to improve. There are calls for awareness-raising among adolescents' teachers and guardians. Furthermore, the policy environment favours delivering clinical SRH services only to married adolescents. [146]

Box 5 Adolescent-friendly health centers in Bangladesh

Adolescent friendly health centers (AFHCs) focus on improving access to SRH information, counseling and clinical services. They are built within the existing general health care facilities, which may reduce the stigma and other barriers experienced by unmarried girls, and might fill a critical gap in service provision for vulnerable adolescents. The Population Council is evaluating the impact of AFHCs in Bangladesh to inform investments and guide their future expansion.

Source: Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

[141] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020
[142] UNFPA (2016) Sexual and Reproductive Health Laws and Policies in Selected Arab Countries
[143] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020
[144] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[145] ARROW (2016) Bangladesh Advocacy Brief: Comprehensive Education: the way forward
[146] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

5. FINDINGS ON SEXUAL AND REPRODUCTIVE HEALTH EDUCATION (SRHE) IN SELECTED COUNTRIES

The desk review considered SRHE policies, plans and programmes, the Islamic perspective on SRH education, adolescents' knowledge of SRH, barriers to SRHE, and monitoring and evaluation of SRHE programmes across the selected countries, which are presented in this section to inform the 2020-24 PEKERTI Plan of Action.

5.1 Policies related to sexual and reproductive health education

A 2019 comparative review of adolescent CSE across cultures identified many gaps and inadequacies and noted that different societies implement different policies. Evidence-based policies and programmes for sexuality education, including evaluations, are limited, particularly in the Asian context.[147]

Malaysia

In Malaysia, the MoH developed the *National Adolescent Health Policy* (NAHP) in 2001 and the *2006-2020 National Adolescent Health Plan of Action* (NAHP PoA) in 2007 to empower adolescents (aged 10-19 years) with the appropriate knowledge and assertive skills to enable them to practice healthy behaviours and lifestyles.[148] SRH is one of the five priority areas outlined in the NAHP PoA, which operationalises the seven strategies of NAHP via a set of activities developed by the government and NGOs working with adolescent programmes. [149] The MoE and LPPKN are the primary national providers of SRHE. MoH provides SRHE to clients walk-in service centers, whereas LPPKN, MoE, and NGOs provide SRHE to target groups.

Turkey

The Turkish *2013-17 National Strategic Health Plan* included raising reproductive health awareness to encourage healthy behaviours. The objective was to change individuals' behaviours through programmes and activities aimed at promoting reproductive health, improving reproductive health services, safe abortion services, and the effectiveness of pre-marital counselling services via intersectoral cooperation.[150] Turkey does not have a national multisectoral young people's policy. Preoccupation with women's chastity led to the *Statute for Awards and Discipline in High School Education 1995*, which stated that *proof of unchastity* was a valid reason for expulsion. *Non-consensual genital examinations* resulted in many suicides among young girls. In 2002, the MoE abolished the *proof of unchastity* clause following advocacy from the Turkish women's movement and international human

[147] Leung H, Shek DTL, Leung E, Shek EYW (2019) Development of Contextually-relevant Sexuality Education: Lessons from a Comprehensive Review of Adolescent Sexuality Education Across Cultures. International Journal of Environmental Research and Public Health 16:621.
[148] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[149] Ministry of Health Malaysia (2015) National Adolescent Health Plan of Action
[150] WHO (2015) Strategic planning for health: a case study from Turkey

rights organisations.[151] Turkey ratified CEDAW in 1985. The CEDAW Committee reviewed Turkey's 2014 Periodic Report in 2016, and made the following recommendations: ensure the integration into the school curricula of mandatory, age-appropriate SRH education, particularly the prevention of STIs, early pregnancies and violence as well as equal and full access to SRH information and services, including refugees and asylum seekers women and girls to safeguard the legal right to abortion and contraception; and renew the national strategic action plan for HIV/AIDS.[152]

Egypt

The 2013 report of the Egyptian Initiative for Personal Rights records that no single institution is responsible for SRH education services in Egypt. Despite some government support of existing civil society initiatives, particularly the National Council on Motherhood and Childhood, the necessary institutional and political framework for SRH education is lacking.[153] However, this is expected to change with the implementation of the *2015-30 National Population Strategy*. The Strategy contains education goals directed at youth and those of reproductive age. The education topics include family planning methods, the value of smaller family size, SRH and GBV. The intention is to target groups with high fertility and those living in poverty. The education programme will be delivered via sport festivals and via NGO door-to-door visits, training religious and community leaders (Muslim, Christian) on family planning.[154]

No information on SRHE policies was found for Morocco or Bangladesh, although we can assume their existence as SRHE is being conducted albeit limited, as noted below.

5.2 Sexual and reproductive health education programmes across selected countries

5.2.1. School-based SRH programs

The introduction of CSE education into the school curriculum is considered the most effective and cost-efficient initiative for reducing STIs and HIV infection and unintended pregnancies among adolescents.[155] School-based programmes increase adolescents' awareness, knowledge, and understanding of SRH issues via sessions delivered on school premises and built into students' schedules. They reach many adolescents simultaneously and foster strong sustained participation as part of the regular school day and involve the teachers and school management's active participation. The approach legitimises SRH education for adolescents, their parents, and other gatekeepers.[156]

[151] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[152] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[153] Roushdy N (2013) Sexuality Education in Egypt: A Needs Assessment for a Comprehensive Program for Youth
[154] UNFPA (2020) Egypt National Population Strategy 2015-30 progress review - Year 2
[155] UNESCO (2015) Emerging evidence, lessons and practice in comprehensive sexuality education: a global review
[156] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

A whole-school approach has been effective in delivering quality SRH education and building the gatekeepers support (teachers and parents) for the CSE curricula. This approach also involves the participatory engagement of community leaders and progressive religious figures. It engages men and boys in SRH issues such as equality, empowerment and human rights, building partnerships with community, service-related resources and NGOs and making CSE accessible across the community. Adaptation of the whole-school approach combined with critical pedagogical methods (a curriculum based on students' interests, cultural needs and community empowerment; a participatory teaching approach to promote dialogue; and space for critique and reflection among students and teacher) should include a gender and power relations analysis framing the discussions.[157]

Malaysia

In Malaysia, SRH education was introduced by the MoE into the secondary school curriculum in 1989 and further extended to primary schools in 1994 via the Family Health Education curriculum.[158] In 2011, the SRH education curriculum was updated and renamed Reproductive Health and Social Education (Pendidikan Kesihatan Reproduktif dan Social or PEERS) and implemented in primary and secondary schools from Year One of Primary School to Form Five of Secondary School (ages 7-18 years).[159] The PEERS curriculum incorporates a range of topics from personal hygiene to life skills, self-respect and negotiation skills and emphasises moral values. Trained teachers teach PEERS for 30 mins per week in primary schools and 40 mins per fortnight in secondary schools. [160] The PEERS curriculum is integrated into physical education, health, Islamic studies, biology, science, and moral and physical education,[161] considering pupils' context, religion, and culture.[162] The MoE has collaborated with governmental and NGOs to implement PEERS.

PEKERTI@School is a holistic and comprehensive programme that encompasses the biological, socio-cultural, psychological and spiritual aspects of SRH education. The MoE collaborates with LPPKN to implement the PEKERTI programme. The "I'm in control" module is run by LPPKN for PT3 students (Secondary/Form 3). HEALTH for Adolescent was run by FRHAM for Primary Six pupils during 2011-15. The MoE has allocated 16 hours per year to other health education that addresses social problems such as sexual abuse and pedophilia. The Family Health Education (PKK) module integrates language, science, additional science, biology, health, life skills, Islamic and moral subjects. In health education class, PKK is given a special focus for pupils from Year One of Primary School to Form Five of Secondary School. PKK is divided into five modules: Physical, Social, Gender, STIs, and HIV-AIDS. MoE teachers who were qualified and capable of teaching PEERS also taught other programmes such as Parental Support (Sarana Ibu

[157] Gunasekara V (2017) Coming of age in the classroom: religious and cultural barriers to Comprehensive Sexuality Education. ARROW
[158] Ministry of Education, Pelaksanaan Pendidikan Kesihatan Reproduktif Dan Sosial (PEERS) Melalui Kurikulum Pendidikan Kesihatan
[159] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[160] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[161] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[162] Information provided by the MoE representative within the TWC

Bapa) and Community Owned Schools (Sekolah Milik Masyarakat) to parents and the community. The approach supported students' SRH education.[163] However, the current curriculum excludes contraception information and other safe sex methods (
Table 7),[164,165] and the content is non-examinable.[166] Feedback from teachers noted the shortcomings in training, support, and school leadership commitment.[167]

Table 7 The current integration of SRH topics in the PEERS curriculum [168]

Level	Age category	PEERS content	Subject
Primary levels 1, 2 and 3	Children aged 7–9	Physical differences between boys and girls Personal hygiene, responding to social situations that may lead to unsafe sexual contact, the importance of preserving one's self-respect and emotional management	Physical and Health Education
Primary levels 4, 5 and 6	Early adolescents aged 10–12	Conflict management, puberty and physical changes, the reproductive system, skills needed to preserve one's self-respect, the risks of premarital sex, the spread of STIs, how to refuse cigarettes, alcohol and narcotics.	Family Health
Secondary levels 7,8 and 9	Middle adolescents aged 13–15	Social psychology, life skills needed to handle high-risk situations, stress management, the transmission of STIs, sexual growth traits, identity and sexual orientation, relationships and the adverse effects of alcohol, cigarettes and narcotics.	Biology, Science, Islamic education, Moral
Secondary levels 10,11 and 12	Middle adolescents aged 16–18	Social psychology, emotional and mental stability, youth pregnancy, family issues, the spread of STIs and preventive measures against cigarettes and narcotics.	Physical and Health Education

Turkey

In Turkey, school and tertiary-based SRH education programme implementation is minimal (some consider it practically non-existent) due to religious and conservative politics. Sexuality is taboo.[169,170] An evaluation of SRH education integration into the 2002-03 school curricula (Grades One to Eight; ages 7-14) by the *Development of Health Awareness in Adolescent Project Science Committee* (**Box 6**) concluded that important aspects were missing. The aspects included physical development, sexuality and sexual development, including pregnancy and birth, unintended pregnancy, sexual identity, changes in adolescence, sexual violence and abuse, birth control, and sexual discrimination.[171]

[163] Information provided by the MoE representative within the TWC.
[164] Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[165] Mokhtar MM, Rosenthal DA, Hocking JS, Satar NA (2013) Bridging the Gap: Malaysian Youths and the Pedagogy of School-based Sexual Health Education. Procedia - Social and Behavioral Sciences 85:236–245.
[166] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[167] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[168] Table extracted from Hazariah AHS, Fallon D, Callery P (2020) An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia. Comprehensive Child and Adolescent Nursing 0:1–17.
[169] Sayin U (2015) Problems in Sexual Education and Sex Therapy in Turkey. International Anatolian Twin Congress on Neuroscience and Sexual Health, 1-3 May, 2015 at: Kozyatagi-Hilton, Kadiköy-Istanbul-Turkeyaffiliation: Istanbul University
[170] Bikmaz FH, Guler DS (2007) An Evaluation of Health and Sexuality Education in Turkish Elementary School Curricula. Sex Education: Sexuality, Society and Learning 7:277–292
[171] Bikmaz FH, Guler DS (2007) An Evaluation of Health and Sexuality Education in Turkish Elementary School Curricula. Sex Education: Sexuality, Society and Learning 7:277–292

SRH education in Turkey is an unmet need for young people, particularly vulnerable girls. Secondary school students receive information on reproductive health in biology lessons as part of the national curriculum, and human reproduction information is restricted.[172] Few tertiary Institutions offer an elective sex education course.[173] Medical courses do not cover SRH issues from a rights-based perspective. Health professionals have inadequate knowledge about HIV infection. People living with HIV/AIDS experience substantial stigma and discrimination, discouraging health-seeking behaviours for those affected.[174] Nevertheless, there have been several attempts to pilot CSE school programs (**Box 6**).

Box 6 SRH Education initiatives in Turkey

The 2001-05 Development of Health Awareness in Adolescent Project
The *2001-05 Development of Health Awareness in Adolescent Project,* supported by UNFPA in partnership with the Ministry of Education, the Ministry of Education Health Affairs Administration, and the Human Resource Development Foundation, aimed to:

1. collect and report youth health data (conducted by the Women and Children's Health Education and Research Unit within the Istanbul Medical School with the results presented to key stakeholders for review
2. incorporated SRH education into the undergraduate curricula of education faculties
3. make sexual and health education more widespread, and to train faculty members who will teach these courses
4. provide in-service training to teachers on subjects related to the health of adolescents; and
5. contribute to the development of adolescent health in the curricula of schools run by the Ministry of Education

Goals 2, 3 and 4 were oprerationalised by making sexual health education courses available as electives at undergraduate level to teacher candidates and to teachers through in-service training between 1999 and 2004. Goal 5 was operationalised by the Development of Health Awareness in Adolescent Project Science Committee (PSC) formed by key stakeholders (pediatricians, psychiatrists, developmental psychologists, gynecologists, curriculum development specialists, NGOs, the Ministry of Education, the Ministry of Health and UNFPA) examined existing evidence for SRH education, narrowing seven basic subject topics: Healthy Beginning to Life, Healthy Physical Development, Healthy Intellectual, Emotional and Social Development, Healthy Living Habits, Protection from External Factors, Positive Social Relations and Effective Use of Health Services.

Source: Bikmaz FH, Guler DS (2007) An Evaluation of Health and Sexuality Education in Turkish Elementary School Curricula. Sex Education: Sexuality, Society and Learning 7:277–292

Pilot study for a CSE programme in Turkey
A 2007 study piloted a five-step CSE programme for those aged 12-14 years based on international guidelines and adaptation to the Turkish cultural values. The curriculum included an eight-session interactive programme with parental permission and involvement delivering five units: human development, relationships, sexual behaviour, sexual health, and society/culture. The programme content and related knowledge assessment tool were validated by Turkish professionals and was piloted with a group of Turkish adolescents with positive results.

Source: Cok F, Gray LA (2007) Development of a sex education programme for 12-year-old to 14-year-old Turkish adolescents. Sex Education 7:127–141

[172] Yilmaz V & Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. *Societies* **2020**, *10*, 33.
[173] Alper Çuhadaroğlu (2017) The effects of sex education on psychological counselling students in Turkey, Sex Education, 17:2, 209-219,
[174] Yilmaz V & Willis P (2020) Challenges to a Rights-Based Approach in Sexual Health Policy: A Comparative Study of Turkey and England. *Societies* 2020, *10*, 33.

Egypt

In Egypt, apart from some government support of existing civil society initiatives, particularly by the National Council on Motherhood and Childhood, the necessary institutional and political framework for SRH education is lacking. The MoE introduced a few short lessons on reproductive health, reproductive physiology, and family planning into students' science curricula pre and post-ICPD. However, the content was inadequate. [175] Pre 2011, reproductive health was part of the health education curriculum. It introduced family planning and the impact of population growth in Egypt into religious studies in Grades 9 and 12. The science syllabus for the second year of Preparatory School (Grade 8) contained a description of the structure and functions of the male and female genital systems and a brief mention of reproduction. The only genital diseases discussed were puerperal sepsis (genital infection after delivery) and syphilis. However, following the 2011 revolution and the subsequent political instability, the newly appointed Minister ordered the removal of these topics and family planning methods from the curriculum. [176]

By 2017, Egyptian public schools provided limited information on aspects of SRH. Little is known about the delivery of the information or how students reacted to it. In most Egyptian classrooms, if SRH topics are covered, it is under biology and not presented in detail. SRH sections might be skipped or inadequately covered because teachers are unprepared or embarrassed. [177] A 2012 study conducted in three governorates of Egypt revealed that students consider the SRH school-based curriculum is insufficient; teachers and students are shy and embarrassed during these lessons.[178] Teachers do not always deliver the curriculum; they often ask pupils to read it at home or discuss it with their parents. The lesson content is not examined. SRHE is revisited in Grade 12 Biology; the last year of secondary school.[179] However, successful school pilots have been implemented, although very few have been scaled-up.

Morocco

SRHE remains a controversial issue in Morocco, and CSE is absent from schools. Public schools must deliver a class called *Education in Health Reproduction* to the last year of middle school and first two years of high school. The curriculum includes biological information on human reproduction but omits other aspects of sexuality. The class is delivered at the end of the school year, and attendance is not enforced.[180] The *2011-20 Strategy* noted that a SRH education programme is delivered in schools and universities and includes family planning methods and contraceptives. The SRH modules were introduced in the fifth and sixth year of Medicine courses and included STIs, prenuptial consultation, uterine, cervical and breast cancer. No specific information could be found about the SRH curricula. In

[175] Roushdy N (2013) Sexuality Education in Egypt: A Needs Assessment for a Comprehensive Program for Youth
[176] Wahba M, & Roudi-Fahimi F. (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau
[177] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[178] Geel FEZ (2012) Quality Sexual Education Needed for Adolescents in Egyptian Schools.
[179] Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau
[180] Feldman E (2020) Sex education in Morocco? There is an app for that. In: Reporting Morocco.

2014, the Moroccan Ministry of National Education and the Moroccan Modern Industries agreed to implement a new programme to sensitise and educate young people in hygiene practices, life skills, STIs prevention, and early marriage and family planning,[181] although no further information was found.

Bangladesh

In 2012, the Bangladeshi MoE's National CurriCulum and Textbook Board introduced adolescence and reproductive health into the curricula of Classes 6 to 10 (
Table 8). However, not in great detail. While no research is available on the implementation or effectiveness of the national SRH curriculum, reports indicate non-implementation due to teachers' reluctance to teach SRH in the classroom; students are asked to read the chapters themselves. Teacher sensitisation, training, and support are required for effective implementation, robust research designs, and rigorous monitoring and evaluation.

In Bangladesh, school-based SRH programmes are relatively new and have not been extensively used or evaluated Significant barriers to effective implementation of school-based programmes exist and include permission from school management committees and the MoE for SRH curricula, and the coordination and linkage of SRH education with health services. A significant barrier is inadequate training of teachers to deliver school-based SRH programming effectively.[182] The curriculum's current broad message is to advocate for abstinence-only, particularly for women and girls, in line with preserving religious morals. [183]

Table 8 Sexuality topics introduced in Bangladeshi schools in 2012 [184]

Class 6	Class 7	Class 8	Class 9 - 10
Physical, psychological changes during puberty	Physical, psychological and sexual abuse	AIDS Awareness: Symptoms and prevention	Physical, behavioral and psychological changes
Role of parents during puberty	Physical and psychological wellbeing – ways to protect and reaching out for help	Early pregnancy: Risks and consequences	Coping with mental pressure during puberty
Dos and don'ts during menstruation	Addiction: Consequences and prevention	Reproductive health	Reproductive disease (Cancer, HIV)
Nutritious and balanced diet	Early marriages and dowry		Preventing early pregnancy
Peer pressure in adolescents – smoking and alcohol			Safe motherhood

[181] Morocco World News (2014) New Agreement to Introduce Sex Education in Moroccan Schools. In: Morocco World News.
[182] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[183] Gunasekara V (2017) Coming of age in the classroom: religious and cultural barriers to Comprehensive Sexuality Education. ARROW
[184] Ainul S, Bajracharya A, Reichenbach L, Gilles K (2017) Adolescents in Bangladesh: A situation analysis of programmatic approaches to sexual and reproductive health education and services. Population Council

5.2.2 Out-of-school programmes

Out-of-school programs are critical to reach adolescents outside the educational system. They include peer education and premarital counselling initiatives (**Box 7**).

Box 7 Peer education and premarital counseling initiatives

Peer education
Peer educators are volunteers of similar age as the target population trained to deliver SRH information, counselling, and referrals to Youth Health Services to their peers. Peer models are relatively inexpensive, a more sustainable and easier to implement, as they access existing informal social networks with which adolescents may be more comfortable discussing culturally sensitive SRH issues. Evidence shows that adolescent peer-led interventions could be effective in changing knowledge and attitudes. A 2018 systematic review of peer-led sexual health education interventions in developed countries with mostly low or no responsibility to peers noted improvements in sexual health knowledge and attitudes in most studies examined; two studies identified improved self-efficacy, and three identified behavioral changes. Meta-analysis revealed a large effect on knowledge change and a medium effect on attitude change.[1]

Premarital counselling
A meta-analytic review of evaluating the effectiveness of premarital prevention programs concluded that they are generally effective in producing immediate and short-term gains in interpersonal skills and overall relationship quality and these improvements are significantly better than non-intervention couples.[2] Premarital courses have been delivered as part of the 2009-12 PEKERTI programme in Malaysia. In Morocco, engaged couples undertake a compulsory pre-marriage consultation which includes STIs testing for the couple to issue a premarriage certificate. The premarital consultation content, scope and informational material is under review.[3] In Egypt, young people receive SRH information and services during premarital services provided by the MoH in Youth Health Counseling Centers.[4]

[1] Sun WH, Miu HYH, Wong CKH, et al (2018) Assessing Participation and Effectiveness of the Peer-Led Approach in Youth Sexual Health Education: Systematic Review and Meta-Analysis in More Developed Countries. J Sex Res 55:31–44
[2] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[2] Carroll JS, Doherty WJ (2003) Evaluating the Effectiveness of Premarital Prevention Programs: A Meta-Analytic Review of Outcome Research. Family Relations 52:105–118.
[3] Morocco World News (2014) New Agreement to Introduce Sex Education in Moroccan Schools. In: Morocco World News.
[4] Roushdy N (2013) Sexuality Education in Egypt: A Needs Assessment for a Comprehensive Program for Youth

Malaysia

LPPKN and FRHAM have developed and deliver several out-of-school educational programmes to address adolescent SRH via IEC materials and adolescent SRH training modules, and include family planning and HIV.

The LPPKN young people programme includes the *I Am in Control* module providing SRH information on sexuality, responsibilities, unintended pregnancies, STIs and HIV, abortion and abandoned babies, techniques/skills to avoid pre-marital sex and information on safe sex. The topics were also adapted into a training module for young people who participated in the National Services Programmes. The National Services Programmes, following Malaysian cultural and religious values advocated abstinence-only and excluded life-skills such as condom use and other contraceptives. *I Am in Control* contains a separate section on contraceptives for sexually active and high-risk adolescents.

KafeTEEN, an adolescent centre led by LPPKN, uses a peer educators' approach and focuses on SRHE. KafeTEEN is supported by the MyKafeTEEN mobile app for those unable to reach the center. The PEKERTI out-of-school programme targets high-risk groups and hot spots areas and provides capacity building for community leaders and NGOs. Other LPPKN initiatives included a module designed to enable teachers to implement the programmes in schools after students complete the year six Primary School Examination. An equivalent programme is planned for the junior high school students upon completing their Lower Secondary School Examination. The *Training of Teachers* module to support the programme was piloted in over 30 schools. The evaluation has not been published yet. [185]

FRHAM has implemented adolescent SRH and rights education across the country via its 13 member associations. The objective is to empower adolescents to make informed choices. The implemented approaches include an adolescent peer-based approach and an electronic version of the Reproductive Health of Adolescents Module. FRHAM is also providing SRH and HIV prevention information through peer education to disadvantaged young people in juvenile homes run by the Department of Social Welfare.[186]

Turkey

In Turkey, UNFPA is collaborating with NGOs, including the Turkish Family Health and Planning Foundation, to address the most vulnerable groups' SRH rights and needs. Young people are reached via peer education models implemented by NGOs responding to vulnerable adolescents' needs, including young Syrian refugees. The programme includes awareness-raising efforts (e.g. theatre-based trainings), advocacy for youth health services, access to SRH education in schools (via SRH capacitation workshops for teachers and school counsellors), child marriage, and adolescent pregnancy.[187]

Egypt

Some programmes provide youth hotlines or websites (shababna.org) for SRH information services to young people in Egypt. International NGOs offer most SRH education programmes. [188]

Morocco

The Moroccan Government is revising the SRH and family planning informational materials and implementing several SRH-related programmes: a young people's health programme integrating SRH information and services via YHCs. The programme includes contraceptive knowledge and use, a pre-marital consultation programme, a menopause programme, and health professional training in perinatal care.[189] As discussed in Section 4, the NGO sector (AMPF, ALCS, OPALS) provides several SRH education programmes and services to vulnerable populations.[190]

[185] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[186] Huang Soo Lee M, Lim SC (2012) Addressing the Unmet Need for Family Planning Among the Young People in Malaysia
[187] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[188] Roushdy N (2013) Sexuality Education in Egypt: A Needs Assessment for a Comprehensive Program for Youth
[189] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020
[190] Morocco Ministry of Health (2011) National Reproductive Health Strategy 2011-2020

Bangladesh

Peer education is a common model for adolescent SRH awareness-raising in Bangladesh: two-thirds of the 32 programmes reviewed by the Population Council employed peer-led models. Of the 9 adolescent SRH focused programmes in the Population Council review, 7 employed a peer educator model in combination with other interventions, e.g., community-based approaches. However, there is limited evidence for the effectiveness of peer education programmes. The programmes require rigorous monitoring and evaluation standards to ensure their effectiveness in delivering positive impacts for adolescents.[191]

5.2.3 Community-based interventions

Egypt and Bangladesh both have community interventions and community mobilization.

Several NGOs in Egypt deliver SRH education via innovative community-based programmes and extracurricular activities outside of the formal public-school system. The *Ishraq* programme in rural Upper Egypt trained peer mentors, worked with parents, informed the community and provided safe spaces at youth centres to empower girls and young women.[192] *Maalouma* is Egypt's first website to provide information on SRH information and online youth services. [193] It publishes articles, provides private counselling services through text messaging, and offers e-learning modules and infographic material and other web content on sexuality.

Bangladesh has extensively employed community-based models to deliver adolescent SRH programmes. Nearly all programmes reviewed by the Population Council incorporated some form of community-based model to raise awareness about SRH issues, often in combination with school-based or health facility based-models, or with media campaigns. They deliver SRH education and social services, combined with age-appropriate recreational activities in common community spaces such as village squares, courtyards and playgrounds, or via adolescent clubs or youth centers. The Population Council review noted that community-based models benefit advantaged young people (older, unmarried, literate, in school). Designed to reach adolescents in general, they fail to reach more vulnerable younger, married and out of school adolescents. Community-based models are also difficult to implement in urban settings where communities lack social cohesiveness and stability and are highly mobile.[194] However, Bangladesh is integrating school-based and community-based approaches (**Box 8).** Two specific community-based interventions deserve special attention: community mobilisation and social and behavioral communications.

[191] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[192] Sieverding M, Elbadawy A (2016) Empowering Adolescent Girls in Socially Conservative Settings: Impacts and Lessons Learned from the Ishraq Program in Rural Upper Egypt. Stud Fam Plann 47:129–144.
[193] Zohney, S. (2016). Sexual rights and the internet in Egypt. Mada Masr.
[194] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

Box 8 Lessons from Bangladesh: integration of school-based and community-based approaches

A study comparing recruitment, acceptance, and participation between the school-based and community-based models showed that **recruitment and participation was better in the school-based models**, compared to community-based models. **However, community-based models generated greater enthusiasm and openness among participants.** Since teachers may not feel prepared or comfortable addressing culturally-sensitive SRH issues, community-based models may also be a more feasible channel for sharing information and discussing those topics than schools. The Population Council review suggests that although most programs are set either in schools or in communities, **there is an increasing use of integrated approaches that work both in schools and communities, taking advantage of the strengths of both models**.

Source: Ainul S, Bajracharya A, Reichenbach L, Gilles K (2017) Adolescents in Bangladesh: A situation analysis of programmatic approaches to sexual and reproductive health education and services. Population Council

Community mobilisation

Community mobilisation targets gatekeepers and decision-makers in adolescents' lives (parents, community leaders, religious teachers) to sensitise them on SRH issues and gain acceptance and support in implementing SRH programming. Acceptance and support are critical for the programme's success in conservative contexts. Community mobilisation is a popular approach in Bangladesh, typically combined with other awareness-raising approaches. Community mobilisation components were identified in all 32 programmes reviewed by the Population Council. [195]

The Egyptian Family Health Society has been advocating for young people's SRH education nationwide, convening several youth and adolescent health conferences in Cairo (**Box 9**). The 2011 conference participants recommended that school curricula be revised to include SRH and life skills for young people. EFHS followed up on these recommendations with an expert meeting from the MoE's curriculum unit. A task force was formed with four curriculum experts and four SRH experts to define health education and life skills topics for inclusion in the curricula of primary, preparatory, and secondary schools. The draft curricula were presented to the Minister of Education following a 2012 workshop.[196]

[195] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

[196] Wahba M, & Roudi-Fahimi F. (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau

Box 9 National Conferences on Youth and Adolescents Health in Egypt

The Egyptian Family Health Society convened three National Conferences on Youth and Adolescents Health in Cairo in 2001, 2011 and 2013, bringing together experts from Egypt and overseas, including government, NGOs, national and international experts, including government, youth representatives (to voice their opinions and concerns), and the media. Participants fully supported the youth's rights to have information and access to counseling and services related to their general and reproductive health. The World Programme of Action for Youth to the Year 2000 and Beyond, first adopted by the UN General Assembly in 1995, was used as the framework for youth-related organisations. Participants made the following recommendations at the 2011 national conference:

- Form a National Task Force to promote and coordinate activities related to reproductive health education.
- Review and update school curricula to include reproductive health education issues as a basic subject.
- Provide life-skills programmes for young people both inside and outside schools.
- Encourage youth-friendly centers to provide services that coincide with needs and expectations of youth, including premarital reproductive health care.
- Improve the knowledge and skills of those working with young people regarding medical, social, and legal aspects of youth and adolescent health.
- Include Adolescent Medicine in postgraduate studies in medical and nursing schools.
- Encourage studies and research on youth health and use the findings to shape policies and programmes.
- Establish specific youth departments and programmes in the different media outlets.
- Use social media to provide health education and life-skills information.
- Identify and replicate successful national, regional, and international experiences after adapting them to suit local culture.
- Hold the Youth and Adolescents' Health Conference at regular intervals to monitor progress.

Source: Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau

Social and Behavior Change Communication

Social and Behavior Change Communication (SBCC) strategies can generate greater public awareness, desensitise SRH issues and generate open discussion on SRH education and services. A guide was developed for Egypt (**Box 10**), which could inform Malaysia's SBCC plan.

Box 10 Social and Behavior Change Communication: Guide to Designing Sexual and Reproductive Health Programmes for Youth in Egypt

The Johns Hopkins Center for Communication Programs developed in 2017 the *Social and Behavior Change Communication: Guide to Designing Sexual and Reproductive Health Programs for Youth in Egypt* to provide programme managers, designers and implementers a selection of essential elements and tools to guide the creation, or strengthening, of SRH social and behavior change communication (SBCC) for programmes targeted at youth aged 15-24 years. The Guide is designed to teach these essential elements of SBCC programming and to help users apply the elements to their own work using a set of included worksheets. The essential elements that form the structure of the Guide are:

- Collecting Helpful Information about Youth
- Navigating the Environment for Youth
- Segmenting Your Audience
- Creating an Audience Profile
- Establishing Behavioral Objectives and Indicators
- Identifying Communication Channels in the Community
- Developing Messages for Youth

Source: Cok F, Gray LA (2007) Development of a sex education programme for 12-year-old to 14-year-old Turkish adolescents. Sex Education 7:127–141

5.3 The Islamic perspective of SRH education and gender roles

Sexuality education remains a controversial issue across the selected Muslim countries. Young people are mostly absent from discourses and policymaking around sexuality resulting in a gap between perceptions and current practices. Despite the limited evidence on how Muslim young people engage in premarital sexual activity, available evidence highlights a growing tension between norms and young people's desires and practices.[197] The developmental needs of adolescents, including SRH education and services, tend to receive inadequate attention or be legally constrained. Issues surrounding SRH remain a cultural taboo, especially for adolescents and young unmarried people.[198]

Islamic interpretations of women's role and status in society greatly impact women's empowerment in matters of sexuality. Traditional gender roles across these predominantly Muslim countries of mostly Sunni faith are pronounced, particularly those with high gender inequalities (Egypt, Morocco and Bangladesh). Despite progressive legislation in Turkey and Morocco, women's empowerment remains a challenge across all selected countries. SRH education is limited due to cultural and religious contexts that view sex as taboo. Premarital sexual relationships are prohibited by Islamic Law and disapproved by society. This translates into limited accessible SRH education and services for young people, who face the risk of abuses, STIs, unwanted pregnancies, and social stigmatisation. As discussed, all selected countries have high-level policies mentioning SRH. Morocco has a dedicated National Reproductive Health Strategy, which includes adolescents' knowledge of SRH, STIs and contraception, and notes that

[197] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26

[198] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?

sexuality education is to be delivered in secondary and tertiary educational institutions. However, the desk review found no information regarding the curriculum, and other sources indicated that CSE is not delivered in educational institutions. Both Malaysia and Bangladesh have a dedicated national strategy for adolescent health containing SRH components. Malaysia has a National Adolescent Health PoA to further operationalise the National Adolescent Health Strategy, with SRH being one of the priority areas. In Egypt, the role of SRH education is emphasised in both population and SRH strategies, although implementation is yet to occur. The Turkish *2013-17 National Strategic Health Plan* included raising awareness of reproductive health and encouraging healthy behaviors as objectives to be achieved.

The selected countries do not guarantee adolescents SRH rights and access to accurate SRH information and education, despite the existing legal, political, and institutional frameworks; attributed mainly to religious precepts, several of which are misconceptions.

Conservative social environments, lack of political will and limited multisectoral coordination were identified as key barriers to implementing SRH education in Malaysia,[199] Turkey,[200] and Egypt.[201] SRH education remains a controversial topic across these countries. If delivered within national curriculums in school-based programmes, the content is limited to reproductive health information, promoting abstinence-only to curb what is perceived as moral transgressions such as premarital sex and its consequences. It excludes information on safer sex and contraception. This is despite the evidence noting that CSE is a more effective approach in delaying sexual initiation and reducing the negative health consequences of unprotected sex (

Table 1). In Malaysia, community misconceptions about CSE seem to disproportionately affect girls, particularly Malay girls, who have less access to SRH education and services.[202]

5.4 Knowledge of SRH among adolescents

Reproductive and sexual discourse are taboo topics across the selected countries, resulting in limited SRH knowledge among young people. The 2014 Malaysian Population and Family Survey revealed that SRH knowledge among 13-24 years is minimal. Only about half of those aged 13-17 years could locate reproductive organs, 73% knew that diseases can be sexually transmitted although they had low knowledge of symptoms (23% for males; 18% for females), 34% knew that pregnancy can occur following first sexual intercourse; 33% knew condoms prevent STIs; 45% had contraceptive knowledge (38% in those aged 13-17 years and 54% in those aged 18-24 years) with condoms (82%) and the contraceptive pill (61%) being the most known, 35% were exposed to pornography (61% of those obtained it from the internet), and 4.8% engaged in sexual intercourse (2% in the 13-17 years and 8% in the 18-24 years), with only 35% having used contraceptives, revealing that Malaysian young people are engaging in premarital sex without protection. About half of those surveyed had a girlfriend/boyfriend,

[199] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?
[200] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[201] El-Hameed D (2015) Sexuality Education: Egypt's Missed Opportunity. In: TIMEP.
[202] Wong LP (2012) An exploration of knowledge, attitudes and behaviours of young multiethnic Muslim-majority society in Malaysia in relation to reproductive and premarital sexual practices. BMC Public Health 12:865.

21% had kissed, 13% had sexually touched; 20% have masturbated, 3% have used telephone sex, and 2% had engaged in cybersex.[203]

Turkey's young people (one-third of the population) are exposed to misconceptions regarding sex and sexuality. Most studies consistently demonstrate that adolescents have important information deficiencies about reproductive health and sexuality. The *1999-2003 Project of Change in Adolescence*, conducted by the MoE surveyed 814,177 students in 2670 schools. The Project of Change revealed that half of the 6th, 7th and 8th grade students had not heard about the opposite sex's reproductive organs and 70% of male students did not know where a baby develops.[204] A Turkish study of 600 elementary school students noted 82% were aware of the changes in their bodies, and 69% had knowledge about the place and function of their reproductive organs. Only 55% knew about puberty. Girls attained this knowledge mostly from their mothers (78%), whereas 25% of boys attained it from the media.[205] Several studies conclude that adolescents are sexually active despite the lack of sexual education.[206] University students have culture-specific and gender-dependent differences in sexual attitudes and behaviours. A study of Turkish university students (20-25 years) revealed that male students engage in more sexually risky behaviours. Although most male students opposed premarital sexual intercourse, the frequency of sexual intercourse among male students (61%) was higher than among female students (18%). The mean age of first sexual intercourse was lower, with 47% using condoms at first sexual intercourse.[207]

Available evidence highlights a gap between Egyptian norms and perceptions and young people's desires and practices. Young people aged 15-24 constitute about one-quarter of the population in Egypt. Egyptian young people receive minimal to no SRH education through the formal school system. Both national and subnational surveys (**Box 11**) reveal young Egyptians lack basic information on SRH topics and consult misleading or inaccurate sources.[208] About 54% of respondents to the 2014 *Survey of Young People in Egypt* (SYPE) respondents aged 13-35 had heard of STIs (60% boys; 48% girls). Of those, 73% had heard of HIV/AIDS. Knowledge increased with age, wealth, education and urban areas. Young people, especially women, have limited knowledge about HIV or its modes of transmission. About 61.5% of all SYPE respondents aged 13-35 (both married and unmarried) knew of contraceptive methods (71.5% of female, 52% of male). Knowledge increased with age, urban setting, and marital status.[209]

[203] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[204] Bikmaz FH, Guler DS (2007) An Evaluation of Health and Sexuality Education in Turkish Elementary School Curricula. Sex Education: Sexuality, Society and Learning 7:277–292
[205] Yazıcı S, Dolgun G, Öztürk Y, Yilmaz F (2011) The Level of Knowledge and Behavior of Adolescent Male and Female Students in Turkey on the Matter of Reproductive Health. Sex Disabil 29:217–227.
[206] Bikmaz FH, Guler DS (2007) An Evaluation of Health and Sexuality Education in Turkish Elementary School Curricula. Sex Education: Sexuality, Society and Learning 7:277–292
[207] Aras S, Orcin E, Ozan S, Semin S (2007) Sexual behaviours and contraception among university students in Turkey. J Biosoc Sci 39:121–135.
[208] Wahba M, Roudi-Fahimi F (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau
[209] Population Council (2014) Survey of Young People in Egypt

Box 11 The longitudinal Survey of Young People in Egypt

The longitudinal Survey of Young People in Egypt (SYPE), involving a nationally representative sample of 15,000 young people age 10-29 from 11,000 households in 2009, of which 10,000 followed up in 2014 (a group aged 13-35 then), is a landmark survey conducted by the Population Council and Egypt Poverty, Gender and Youth Program, offering gender-disaggregated information on SRH, schooling, civic engagement, employment, and other topics. **This survey collected SRH attitudes, beliefs and behaviours and practices from youth regardless of their married status, which is critical to estimate unmet need for contraception and other SRH services.** Results were used to inform youth government policies, including the Population Council's pioneering programs, *Ishraq* and *Neqdar Nasharek*, to empower girls and young women in rural Upper Egypt.

Source: Population Council (2015) Panel Survey of Young People in Egypt (SYPE).

Bangladeshi adolescents face high rates of early marriage, high fertility, limited negotiation skills, and insufficient awareness of reproductive health information. [210] Although extramarital sex is forbidden, studies reveal diverse sexual practices and behaviors practiced both within and outside marriage, particularly among young people. Their lack of adequate SRH information and services often leads to risky behaviors.[211]

5.5 Barriers to implementing sexual and reproductive health education

Several Malaysian studies have assessed the existing PEERS curriculum for SRHE, identified several critical problems related to its content and delivery methods, and proposed several recommendations to overcome them (**Appendix 4**). While the existing PEERS curriculum has expanded its key elements over the years, it remains an abstinence-based curriculum that does not align with UNESCO's CSE guidelines. Teachers lack the training and ongoing support. Thus, they feel uncomfortable delivering the content. Parents are not engaged in the learning process, and students' knowledge of SRH is limited. Institutional coordination is lacking at all levels and there is limited monitoring and evaluation.[212]

In Turkey, long-standing challenges to implementing SRHE include a lack of a national multisectoral young people policy, inadequate information on SRH and CSE in school-based curricula, lack of youth-friendly health services, and a conservative environment.[213] The Egyptian Government is failing to provide CSE to young people due to societal resistance and a lack of political will.[214]As of 2015, a network of local NGOs provides SRHE to boys and girls aged 15-17 backed by the National Council for Childhood and Motherhood, with UNFPA and UNICEF support. [215]

[210] Ainul S, Bajracharya A, Reichenbach L, Gilles K (2017) Adolescents in Bangladesh: A situation analysis of programmatic approaches to sexual and reproductive health education and services. Population Council
[211] ARROW, Country Advocacy Brief (2016): Bangladesh. Comprehensive Sexuality Education: The Way Forward
[212] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?
[213] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[214] El-Hameed D (2015) Sexuality Education: Egypt's Missed Opportunity. In: TIMEP.
[215] UNESCO (2015) Emerging evidence, lessons and practice in comprehensive sexuality education: a global review

In all five countries, Islamic precepts and cultural norms pose challenges to SRH education, especially CSE, at both policy and programme levels. Negative perceptions and misconceptions by the public lead to CSEs low acceptance. Overcoming religious and cultural barriers requires more robust and inclusive coalitions and social mobilisation (including youth-led organisations) for SRH at the local, regional and national levels. Evidence from Bangladesh indicates opportunities for people-centered advocacy at all levels of government. Increasing accountability via monitoring legal and policy developments, making budgetary allocations for CSE, and establishing mechanisms to increase civil society engagement provide other advocacy points.[216]

5.6 Monitoring and Evaluation

There are several reasons for the lack of monitoring and evaluation of programmes, including religious censorship and misconceptions. A scoping of the impact of adolescent SRH programming in LMICs conducted by the International Initiative for Impact Evaluation concluded that very few studies explored the impact of adolescent SRH education programming in Muslim countries. [217] Only information for Malaysia, Morocco and Bangladesh was found.

Malaysia

The evaluation of the SRHE programmes under the 2013-2017 Country Programme Action Plan was sponsored and undertaken by UNFPA in 2017.[218] The evaluation noted several challenges, including the difficulties in measuring progress due to the lack of baseline measures, short implementation time, limited coordination among key stakeholders, inconsistent monitoring and evaluation methods at all levels, and limited funding to implement the programme. Recommendations included: a review of the PEKERTI policy; improve the monitoring and evaluation mechanisms; improve capacity building and research; ensure implementation of the policy across age groups; engage people, public and private sectors, and review the family planning policy accounting for the needs of sexually active and unmarried groups.

The 2017 evaluation of the 2009-12 PEKERTI PoA[219] revealed the weak implementation of PEKERTI. It recommended a comprehensive revision to address the SRH education and services needs of Malaysians urgently. Several challenges were identified, including: a lack of baseline indicators to measure programmatic outcomes, with the existing outcomes not clearly defined; the four-year life cycle on the PEKERTI (2009-12) was insufficient to monitor trends and progress; limited coordination across relevant ministries and agencies resulted in challenges with standardising monitoring and evaluation methods;

[216] Gunasekara V (2017) Coming of age in the classroom: religious and cultural barriers to Comprehensive Sexuality Education. ARROW

[217] International Initiative for Impact Evaluation (3ie), Rankin K, Heard A, et al (2017) Adolescent sexual and reproductive health: scoping the impact of programming in low- and middle-income countries. International Initiative for Impact Evaluation (3ie)

[218] Lembaga Penduduk dan Pembangunan Keluarga Negara (2017) UNFPA-NPFDB Final Project Evaluation Report (MYS4U604): research and Module Development on SRH for Young People 2017, Kuala Lumpur, Malaysia

[219] LPPKN & MWFCD (2017) Draft Evaluation Report of the Implementation of Reproductive and Social Health Policy and Plan of Action

and inadequate financial resources to implement new interventions and expand existing ones. The evaluation of the specific components noted that *Advocacy* met 83.3% of its targets; *Capacity Building* 66.7%; *Research & Development* 33.3%; and *Monitoring & Evaluation* 100%. The Monitoring and Evaluation component was limited to two outcomes: establishing a monitoring and evaluation committee and establishing a technical working committee, with no other measurable indicators).

The evaluation recommended review of the PEKERTI Policy and PoA to make it more outcome-friendly. The recommendations included:

- to develop a more systematic and structured monitoring and evaluation mechanism by establishing technical working and steering committees;
- strengthen the human resources capacity development and programme research and development;
- ensure the policy covers all age groups, not only adolescents and young people;
- encourage people, public and private (3Ps) partnership in its implementation;
- review the FP Strategy, accounting for the unmet SRH needs of those under 18 years and unmarried who are sexually active; and
- consider the complexity and sensitivity of SHR education from a human rights, ethical, religious, health and socio-cultural perspective.

The evaluation further recommended an urgent review of the PEKERTI Policy and PoA.

A 2019 review of Malaysia's progress regarding CEDAW implementation[220] noted that sex education is inadequate and based on religious morals rather than a rights-based approach. Cabinet approved the SRHE curriculum for schools in 2006 but has yet to be fully implemented.

Bangladesh

In Bangladesh, initiatives to address adolescent SRH have been implemented at different times by the government and NGOs. However, activities have often been fragmented and are not well documented or evaluated, making it difficult to know what worked well and what did not. Most programmes conducted a baseline qualitative assessment to highlight success stories but did not apply rigorous impact evaluation methodology to assess the interventions' impact. Moreover, programme documentation did not draw on monitoring data, and implementation processes and lessons learned were rarely documented. **Box 12** details the Population Council's recommendations.[221]

[220] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.
[221] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

Box 12 Population Council's recommendations for implementing SRH education and services in Bangladesh

The Population Council review noted the following recommendations for implementing adolescent SRH education and services:

- Employ multifaceted programmes, combining culturally sensitive SRH education with more acceptable programmes targeting livelihoods, empowerment, maternal health or child marriage
- Expand the number of interventions that specifically target vulnerable demographics, including younger adolescents, unmarried girls, and underserved groups such as boys and urban adolescents.
- Encourage age-appropriate intervention design, through innovative and participatory approaches (story-telling, art-centric and psychosocial approaches, the use of interactive, ICT-based curricula and life skills development, or sports-based programming for young adolescents) to address underrepresented needs of adolescents.
- Strengthen the rigor of monitoring, evaluation and research designs to evaluate current interventions and create a culture of evidence-based programming and policymaking.
- Support the sustainability of Bangladesh's Government in leading the SRH coordination efforts with implementing partners to avoid duplication and fragmented programming and ensure the most efficient use of resources.

Source: Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

Morocco

Morocco's evaluation of the *2011-20 National Reproductive Health Strategy* based on interviews with key informants identified the following implementation barriers: limited coordination and integration of the various SRH services, and lack of awareness of the strategy by healthcare professionals; limited and fragmented statistical capacity, impacting on monitoring; difficulties in centralising the strategy because of long-standing specialised programmes addressing aspects of SRH such as the family planning programme; lack of funding to fully implement the strategy and a need to collaborate with international organisations to support implementation costs; the lack of experienced medical professionals in certain regions; and the lack of an implementation action plan. [222] **Box 13** details the evaluation recommendations.

[222] Abaacrouche, M & UNFPA's technical support (2020) Evaluation of the National Reproductive Health Strategy 2011-2020

Box 13 Evaluation of the Moroccan 2011-20 National Reproductive Health Strategy

The evaluation of the Moroccan *2011-20 National Reproductive Health Strategy* based on interviews with key informants provided the following recommendations

- Form a National Task Force to promote and coordinate activities related to reproductive health education.
- Improve coordination of actors and institutions in the areas of reproductive health
- Educational programmes on various SRH topics have been implemented separately (on STIs, maternal health) but there is a need to integrate the overall SRH educational programme
- Evaluate the level of knowledge of health professionals before designing the educational plan and capacitate health professionals in gender principles and SRH issues (obstetrics, nurses and doctors) and medical students by integrating a SRH module in medicine faculties
- Community engagement in gender and SRH training
- Conduct SRH research: 1) identify barriers to integration of SRH education and services; 2) include all women in reproductive age, not only married women in future surveys; 3) conduct a cost-benefit analysis on implementing SRH education and servicers versus not implementing it 4) identify the impact of improved SRH services on unwanted pregnancies; and 5) identify the savings that investing in women and children's have on productivity, education and the economy
- Increase the effectiveness of SRH communication campaigns (materials and content) targeted to the general public.

Source: Abaacrouche, M & UNFPA's technical support (2020) 2011-20 Evaluation of the National Reproductive Health Strategy

6. DISCUSSION

Preparing children and adolescents to transition to adulthood, where safe sexual and reproductive behaviours and choices are understood and practised, remains a priority for all governments. Malaysia and Turkey are upper-middle-income countries and have higher human development than the low-middle-income countries of Egypt, Morocco and Bangladesh. Egypt and Bangladesh are experiencing high fertility and rapid population growth amidst limited resources and are applying a population control strategy. Conversely, Malaysia and Turkey introduced contraception a few decades ago to control population growth with resulting reductions in fertility below replacement level and are now shifting their population policies to encourage higher fertility and population growth.

Discussion of the desk review's findings is presented in three broad categories: the Islamic perspective as a critical determinant of SRHE in Muslim countries, the extent to which the five countries conduct SRHE, and the need to link SRH education with SRH services.

6.1 Islamic perspective of SRH education

The findings of several previous studies across Muslim countries indicate a strong influence of religion on gender roles, sexuality, and the provision of SRHE and SRH services. The Sunni Muslim faith plays an essential role in accepting SRH education and the extent to which governments can promulgate laws and policies that regulate SRH and SRHE. Governments tend to approach sensitive issues using less confronting and more socially acceptable means, such as terminology. In Malaysia, the term used in PEKERTI is “Reproductive Health and Social Education” avoiding the use of “sexual”. Also, “termination of pregnancy“ is used in the MoH guidelines avoiding the word “abortion” which is used in the Civil Law.

Abortion provides a good example of the role of religion in SRH. The ruling on abortion differs between Muslims and non-Muslims. For all Malaysian women, Sections 312 – 316 of the Penal Code provide an exception to the prohibition against abortion. Compared to many other countries, these provisions can be viewed as less restrictive. A registered medical practitioner might perform an abortion on a woman because continuing with the pregnancy will threaten her life, physical health and mental well-being. For Muslim women, there is also a *fatwa.* Abortion is allowed but discouraged (*makruh*) within 40 days of pregnancy; allowed (*harus*) between 40 and 120 days if the pregnancy threatens the life of the mother and the fetus, and not allowed (*haram*) after 120 days.

Despite the endorsement of the ICPD by the selected countries, they are yet to fulfill all commitments made in the ICPD PoA. Every five years, the ICPD PoA is reviewed. The latest ICPD commitments (after 25 years) were made in Nairobi in November 2019, where a specific call for action on CSE was made.

These five Sunni Muslim countries differ in the manner and the extent of implementing SRH education. The differences are attributed to historical, sociocultural, and geopolitical differences. For example, Turkey became a republic following the fall of Ottoman empire, making it less conservative in its current

practice of Islam. The differences in the four *mazhabs* of schools of thought of Sunni Islam; Hanafi, Maliki, Shafie and Hanbali, which guide the Muslim communities' practices, are factors in these differences. The majority of the population in Bangladesh and Turkey belong to the Hanafi *mazhab*, while Morocco is mostly of Maliki thought. Egypt mostly observes the Shafie school of thought, although there are followers of Hanafi and Maliki. In Malaysia, the Muslim community is overwhelmingly of the Shafie school of thought.

Several articles address the topic of sex education and Islam. Ermayani,[223] highlights the role of parents as primary educators in the family, followed by other teachers including religious teachers, community leaders, and scholars. Ermayani quoted a Professor of Gynaecology: *"We believe that the facts about sex must be taught to children in a way that is appropriate for their age, both by family and school. We emphasize this must be done in the context of Islamic ideology and comprehensive Islamic teachings (kaffah), so that adolescents (in addition to getting correct psychological knowledge) become fully aware of the sanctity of sexual relations in Islam, a grave sin if it tarnishes its holiness, both according to Islamic law and (far more important) in the sight of God. By presenting an advanced content of Islam, we see no reason to avoid sex education (unfortunately this happens in many Muslim countries). We believe it is better to give true teaching than to leave it to give a chance to get the wrong sources and do it quietly with guilt".* Ermayani concludes that *"the role of educators is very urgent to socialize the understanding that sex education in an Islamic perspective so that parents and the community understand sex education is not limited to the guidance of knowledge about the reproduction of men and women."*

It is undeniable that the Islamic world is undergoing a transformation in its sexual discourse and needs to incorporate a more progressive perspective of how sexuality, reproductive rights and women's rights fit into society. Any woman's ability to determine her own reproductive destiny is directly linked to not only individual choice but also her environment and the broader community. A woman cannot make an individual decision about her body if she belongs to a community that provides inaccurate or incomplete SRH education or services. [224] Public health concerns across these countries regarding the consequences of premarital and unprotected sex disproportionately affect girls and women and indicate the urgent need to incorporate a girls' empowerment component within the SRHE curriculum. [225]

6.2 SRH Education programmes

Schools provide the ideal setting for sexuality education, as most children, adolescents and young people are enrolled in the educational system. While there is some form of school-based SRH education in the selected countries, they vary considerably at both policy and programme levels. Religious influences seem a significant barrier for governments to formulate policies and introduce sex education in schools. Where there is school-based SRH education, there are several constraints.

[223] Ermayani, T (2019) Sex education an early age in the perspective of Islam, Proceedings of the 2nd International Conference on Education, ICE 2019, 27-28 September 2019, Universitas Muhammadiyah Purworejo, Indonesia
[224] Tabahi S (2020) The Construction and Reconstruction of Sexuality in the Arab World: An Examination of Sexual Discourse, Women's Writing and Reproductive Justice. Sexuality & Culture.
[225] UN Human Development Programme (2020) Global Human Development Indicators.

Malaysia is leading in the provision of age-appropriate SRH education; it commences at early primary school. Turkey has evaluated school-based SRHE, which concluded that topics such as unintended pregnancy, changes in adolescence, sexual violence and abuse, birth control, and sexual discrimination were absent.[226] No other evaluations of school-based education programmes have been conducted. However, reports indicate that the curriculums are either not being implemented or poorly implemented due to teachers' reluctance to teach SRH education. Teacher training of SRH topics is inadequate and ineffectively supported. Students read these chapters on their own, and parents are not engaged in the learning process. These challenges lead to limited knowledge among school-going children and adolescents of sexuality, reproduction, pregnancy and contraceptive use, making them vulnerable to abuse, STIs and unintended pregnancy.

Efforts should be directed towards better aligning the SRH curriculum with CSE principles and guidelines and include information on safe sex, contraception, human rights, participation, gender equality and power, positive sexualities, and respectful relations. The eight basic concepts outlined by the UNESCO ITGSE should be considered when developing the national curriculum, and incorporating the local context and existing standards and frameworks. CSE should be age-appropriate and commence as early as possible (preferably from age five). [227]

It is critical to sensitise, train, and support teachers, parents, and community and religious leaders to ensure the curriculum's effective implementation. WHO provides an overview of educators' competencies (attitudes, skills and knowledge) for delivering CSE.[228] A whole-school approach is effective in delivering high-quality CSE. It actively engages teachers, parents, and community and progressive religious leaders to develop and deliver the CSE curricula and build community and service delivery partnerships, combined with participatory teaching within a gender and power relations framework. [229]

The desk review found that very little evaluation has been carried out and few programmes have been scaled up. However, pilot projects do provide important insights. Many of these favour participatory approaches to teaching and parents' involvement. The 2010-12 SRH education pilot project by the Egyptian Family Society and the MoE involved young male and female physicians trained in communication and participatory approaches to deliver seminars on health topics of interest to adolescents, resulting in improved SRH knowledge. Importantly, students shared learned information with their networks. Both students and parents consider physicians a more acceptable source of information than teachers. In Turkey, a school programme adapted CSE guidelines to the local context and was piloted in 2007 for secondary school students with interactive sessions and involving parents. It generated positive results. In Bangladesh, school-based SRH education programmes are relatively new

[226] Bikmaz FH, Guler DS (2007) An Evaluation of Health and Sexuality Education in Turkish Elementary School Curricula. Sex Education: Sexuality, Society and Learning 7:277–292
[227] UNESCO (2018) International Technical Guidance on Sexuality Education (ITGSE)
[228] WHO Regional Office for Europe and BZgA. (2017). Training matters: A framework for core competencies of sexuality educators. Cologne: Federal Centre for Health Education (BZgA).
[229] Gunasekara V (2017) Coming of age in the classroom: religious and cultural barriers to Comprehensive Sexuality Education. ARROW

and have not been extensively used or evaluated for impact. Significant barriers to effective implementation have been identified and include teachers who were inadequately trained and supported to effectively deliver the curriculum. [230]

Out-of-school programs are critical to reach adolescents outside the educational system. These services were limited across the five countries. There is poor uptake by adolescents and young people due to stigma or lack of awareness, particularly in rural areas. In Malaysia, several out-of-school SRH educational programmes are delivered by LPPKN and FRHAM, with limited coverage and uptake. In Egypt and Bangladesh, most SRH education programmes are offered by international NGOs pioneering youth SRH programmes, although very few have been scaled up. Community-based SRH programmes have been extensively employed in Bangladesh due to their wide reach, delivering SRH education and some services along with recreational activities in community spaces. In Turkey, UNFPA is collaborating with NGOs (the Turkish Family Health and Planning Foundation) to address the SRH rights and needs of the most vulnerable groups via peer education models, awareness-raising efforts (e.g. theatre-based trainings), and advocacy for Youth-friendly Health Services.[231] In Morocco, YHCs integrate SRH information and services, including contraceptive knowledge and use.

While SRH education programmes are set either in schools or in communities, there is an increased use of integrated approaches that work both in schools and communities, taking advantage of both models' strengths. Bangladesh particularly benefits from this integration, as there are low levels of secondary and tertiary education enrolment.

Premarital counselling programmes generally produce immediate and short-term gains in interpersonal skills and overall relationship quality.[232] However, they are not effective in preventing most adolescent pregnancies and HIV/STIs. These programmes include SRH information and services offered by the Malaysian MoH via youth-friendly health centers, known as Youth Health Services. Morocco provides engaged couples with compulsory premarital consultation, including STIs testing.

Peer education programmes are relatively inexpensive, sustainable, easier to implement and can access existing informal social networks where adolescents may feel comfortable discussing culturally sensitive SRH issues. Evidence indicates that adolescent peer-led interventions could be effective in changing knowledge and attitudes but less so in changing behaviours. Peer education programmes are being implemented by NGOs in Malaysia, Turkey, Egypt and Bangladesh. In Malaysia, FRHAM is training young peer educators with SRH and HIV prevention information among disadvantaged young people. The Turkish Family Health and Planning Foundation is addressing the SRH rights and needs of the most vulnerable groups via peer education models. The Egyptian Family Planning Association provides IEC programmes for the general public, many of which (particularly amongst young people) are run on a

[230] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[231] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey
[232] Carroll JS, Doherty WJ (2003) Evaluating the Effectiveness of Premarital Prevention Programs: A Meta-Analytic Review of Outcome Research. Family Relations 52:105–118.

peer-to-peer basis.[233] Peer education models are commonly use in Bangladesh combined with other interventions. However, rigorous monitoring and evaluation standards should be implemented to peer education components to ensure their effectiveness in delivering positive impacts for adolescents. [234]

Community mobilisation aims to raise awareness in the community targeting gatekeepers and decision-makers in adolescents' lives (parents, community leaders, religious teachers). It is critical for programme success in conservative contexts. The desk review did identify information across all selected countries; there are fairly good findings from Bangladesh and to a lesser extent from Egypt. Community mobilisation is a popular approach in Bangladesh, typically combined with other awareness-raising approaches. [235] The Egyptian Family Health Society has been advocating for young people SRH education nationwide, convening several health conferences in Cairo involving the media.[236] When designing a SBCC plan for Malaysia, it might be beneficial to refer to the SBCC guide to designing SRH programs for young people in Egypt.[237]

As discussed earlier, the level of knowledge of children and adolescents on SRH is both a rationale for CSE (low knowledge) and an outcome of CSE (improved knowledge). The findings show great similarity in all countries; there is inadequate SRH knowledge, thus strengthening the argument for a more effective CSE in the five countries. Young people who lack the needed knowledge are likely to engage in unhealthy sexual behaviours and seek SRH related information from unreliable sources, mainly from friends and increasingly from the internet.

Common challenges to SRH education across countries were expected and identified. The challenges include unclear (or lack of) policies, unclear and/or inadequate curricula, low levels of knowledge among school teachers who lack training and experience discomfort and unwillingness to teach a culturally and religiously sensitive subject. The challenges require effective strategies to overcome them. Social resistance and weak political will are the most urgent and more difficult challenges to be addressed.

Monitoring and evaluation of SRH education is weak in all countries. Interventions across selected countries were implemented at different times by the government and NGOs. However, activities have often been fragmented and are not well documented or evaluated, making it difficult to know what worked well and what did not. Information on monitoring and evaluation of SRH education was available only from three countries; Malaysia, Bangladesh and Morocco. In these countries, the evaluations made several recommendations, including strengthening existing SRHE programmes in

[233] IPPF (2016) Egyptian Family Planning Association
[234] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[235] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council
[236] Wahba M, & Roudi-Fahimi F. (2012) Policy Brief: The Need for Reproductive Health Education in Schools in Egypt. Population Reference Bureau
[237] Johns Hopkins Center for Communication Programs (2017) Social and Behavior Change Communication: Guide to Designing Sexual and Reproductive Health Programs for Youth in Egypt

terms of content and approach, improving inter-sectoral and inter-agency coordination and community engagement, and ensuring programme sustainability.

The 2017 evaluation of PEKERTI[238] identified weak implementation, particularly in two unexpected areas; Research andDevelopment and Monitoring and Evaluation. Ideally, an overall monitoring and evaluation plan should include quantitative and qualitative research at baseline, midline, and end line. Time points and should be developed before programme implementation with appropriate funding. All research efforts should be coordinated to avoid duplication and inform best practice.

6.3 Linking SRH education and SRH programmes and services

SRH education and services must be integrated for maximum impact. In the selected countries, coverage and uptake of youth-friendly services is poor, which requires awareness-raising among adolescents' teachers and guardians. Furthermore, health care providers should have the capacity to deliver SRH information in confidential, non-judgmental, non-discriminatory services to both married and unmarried people. Malaysia commenced universal access to SRH services for all adolescents in primary, secondary and tertiary healthcare facilities nationwide in 2012. The MoH led initiatives to provide SRH services for married and unmarried adolescents via the *2012 Guidelines on Managing Adolescents Sexual and Reproductive Health Issues in Health Clinics* to support Youth Health Services. Despite these services' availability, there is poor uptake due to fear of stigmatization or lack of knowledge about their existence.[239]

In Morocco, the public sector provides multidisciplinary services, including SRH information and services (contraceptive knowledge and use), via YHCs targeting young people. However, uptake among young people is low. Efforts are underway to promote these centers to adolescents by linking them with other activities delivered by the Ministries of Youth, Sports, and Education.

Egypt has established pilot government and non-government youth-friendly clinics. However, their coverage and use remain limited, with most beneficiaries being married women, highlighting the need to address cultural and religious sensitivities.[240] Turkey is experiencing a lack of youth-friendly health services within a conservative environment.[241] Adolescent friendly health centers in Bangladesh focus on improving access to SRH information, counselling, and clinical services within the existing general health care facilities, which may reduce the stigma experienced by unmarried girls. Again, uptake is low.

[238] LPPKN & MWFCD (2018) Draft Evaluation Report of the Implementation of Reproductive and Social Health Policy and Plan of Action
[239] ARROW (2018) Country Profile on Universal Access to Sexual and Reproductive Health: Malaysia
[240] Nagi M (2017) Islam, Sexualities and Education. In: Daun H, Arjmand R (eds) Handbook of Islamic Education. Springer International Publishing, Cham, pp 1–26
[241] UNPFA (2019) 2016-2019 UNFPA Country Programme Evaluation Turkey

Both clinical and non-clinical services lack integration of SRH issues. Clinical SRH services tend to be delivered to married adolescents only.[242]

The above observations have several implications. For example, multisectoral agreements over the programme content and delivery methods and its integration into a government's healthcare priorities should ensure a minimum standard of SRH education and corresponding health services that leave no one behind. A multilevel approach addressing individuals, networks and communities at national, regional and local levels can support the implementation and scale-up of CSE programmes, address conservative opposition, advance international cooperation, and adapt innovation in content, delivery and methodological research.

Finally, it is noteworthy that for Malaysia, the 2009-2012 PEKERTI is both a Policy and a PoA. The request for recommendations was for the PoA only; a Policy normally covers a longer period than a PoA. It is also common practice to first promulgate a National Policy, followed by a National Strategic Plan (covering 5 to 10 years) outlining broad principles and strategies. The subsequent PoA (sometimes referred to as the Operational Plan) covers a shorter timeframe (either one or two years) within the Strategic Plan's lifespan. These plans are more detailed with activities to achieve each of the Strategic Plan's broad strategies and specify the roles and responsibilities of implementing agencies stated clearly for each activity. The LPPKN may wish to explore this approach.

7. LIMITATIONS

This review faced several challenges, including limited time and resources. The published information on SRH education across selected countries was also limited. For instance, governments may not have published SRH related policies and action plans. Secondary data sources were used when government materials were not available. In addition, policies are written in languages other than English. Translation was sourced for official documents from Malaysia and Morocco.

SRHE information from the selected countries focused on children, adolescents and young people. Limited information was found for other age groups. CSE should take a life course approach. Thus, the recommendations incorporate all age groups when referring to the implementation of CSE.

[242] Ainul S, Bajracharya A, Reichenbach L (2016) Adolescents in Bangladesh: Programmatic approaches to sexual and reproductive health education and services. Situational Analysis Brief. Population Council

8. CONCLUSIONS

A range of stakeholders share responsibility for delivering SRHE in Malaysia. While LPPKN oversees and coordinates the overall SHRE in selected school settings and out-of-school settings via KafeTEEN, PEKERTI is implemented by several agencies, including the MoE, which provides SRHE in schools (commonly known as PEERS); and the MoH, which is the main provider of SRH services, including counselling in clinical and community settings via health clinics and Adolescent Health Services. NGOs, notably the FHRAM, use PEKERTI to deliver SRH education to vulnerable groups.

However, a 2019 review of Malaysia's progress regarding CEDAW commitments [243] noted that sex education is inadequate and based on religious morals rather than a rights-based approach. This desk review and the consultative process informing the 2020-24 PEKERTI PoA demonstrate that Malaysia is now taking a proactive approach to improving SRH education and services. The multisectoral consultative process provides the opportunity to design, implement and monitor a more inclusive, comprehensive, engaging and effective SRH education programme that meets the needs of Malaysia's multiracial and multifaith society and improves the integration of SRH education and services. Still, it requires strong leadership and well-trained teachers and health professionals on CSE principles.

The desk review findings indicate that school-based CSE programmes are cost-effective in reaching children, adolescents and young people engaged in education. Community-based out-reach interventions are equally important in transforming harmful attitudes, beliefs and behaviours and ensuring access to SRH information and services for the most vulnerable groups, including out-of-school adolescents. [244] Although CSE components are integrated within Malaysia's school system, a significant gap remains in content and delivery. The gap needs to be addressed via curriculum revision, teacher training and delivery methods to improve information retention and provide effective SRHE. [245] The programmes should be contextualised to address specific adolescent health needs linked to SRH services, and monitored and evaluated over time to identify and scale-up successful interventions and course-correct or terminate unsuccessful ones for best allocation of limited resources. Multisectoral agreements over content and delivery methods and integration into the Government's healthcare priorities should ensure a minimum standard of SRH education and health services that leaves no one behind. A multilevel approach addressing individuals, networks, communities, and religious leaders at national, regional and local levels can support the implementation and scale-up of SRHE programmes, manage conservative opposition, advance international cooperation, and adapt innovation in content, delivery and methodological research.

Malaysia's 2020-24 PEKERTI PoA aims to overcome challenges and enhance the effectiveness of comprehensive and age-appropriate SRH education in formal and informal settings. The findings from

[243] Women's Aid Organisation (2019) The Status of Women's Human Rights: 24 Years of CEDAW in Malaysia.
[244] Vanwesenbeeck I (2020) Comprehensive Sexuality Education. In: Oxford Research Encyclopedia of Global Public Health. Oxford University Press
[245] Lembaga Penduduk dan Pembangunan Keluarga Negara (2017) UNFPA-NPFDB Final Project Evaluation Report (MYS4U604): research and Module Development on SRH for Young People 2017, Kuala Lumpur, Malaysia

this desk review provide important insights to inform the PoA. Likewise, the other four countries can learn from Malaysia's experiences. The recommendations that follow can support the fulfilment of Malaysia's commitment to implementing the PEKERTI PoA by not later than 2021 as part of the ICPD PoA and the 2030 SDG Agenda. [246] Achieving the health, education and gender equality SDGs by 2030 will generate benefits beyond SRH and across other interconnected SGDs. However, it depends on how seriously key stakeholders (government and implementing partners) take the specific SRHR targets and fully implement relevant policies, services, and programs to enhance populations' health and lives and particularly, vulnerable groups. [247]

9. RECOMMENDATIONS

This review proposes a comprehensive, multilevel approach aligned with socio-ecological frameworks based on internationally endorsed CSE principles and guidelines, including those from UNESCO and UNFPA. This approach is likely to be most effective in addressing the identified barriers by targeting adolescents; gatekeepers and decision-makers in adolescents' lives (parents, teachers, community leaders, religious teachers); and policies and services. The following recommendations were endorsed by the TWC. **Appendix 5** provides a comprehensive list of the recommendations.

1. Revive the LPPKN's Advisory and Coordinating Committee for Reproductive Health (ACCRH) to improve the quality of SRHE through multisectoral collaboration and coordination (involving governmental, NGOs and private partnerships), ensuring participatory planning and effective monitoring, and overseeing the implementation of the 2020-24 PEKERTI PoA across the life course (commencing from age five), as well as its full integration into SRH services and programmes.
2. Improve the SRHE curriculum and programmes by allocating adequate financial resources including personnel to build the capacity of SRH service providers and SRHE educators. Reframe SRHE as a health issue (e.g. *family health*) linked to international commitments (SDGs, ICPD PoA, Beijing Declaration and CEDAW) and appealing to contextual values and beliefs while ensuring the adaptation of right-based and gender-focused principles to Malaysia's multiracial and multifaith society.
    a. Adapt the school-based CSE curriculum guidelines and empower children (aged 0-18),[248] adolescents (aged 10-19), and young people (aged 10-24) to make informed decisions by integrating four key components: rights, participation and agency; sexual and

[246] Malaysian Government (2019) Accelerating Malaysia's Progress Towards Implementation of ICPD Programme of Action. In: Nairobi Summit.
[247] Guttmacher Institute (2015) Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals. In: Guttmacher Institute.
[248] According to the following sources

- OHCHR (1989) Convention on the Rights of the Child
- The Commissioner of Law revision, Malaysia (2001) Malaysia Child Act 2001

reproductive health and behaviours; gender equality and power; and positive sexuality and respectful relations.[249]

b. Integrate CSE training in the teachers' syllabus and improve training modules using a participatory teaching approach with follow up and support.
c. Engage parents in the learning process, and engage progressive community and faith-based leaders in delivering a consistent community message to increase support.
d. Improve reach and coverage of SRHE programmes addressing vulnerable communities.
e. Include older people within the PEKERTI PoA by strengthening SRH programmes and services and SRHE for the elderly.

3. Generate social support through community participation and mobilisation via mass media campaigns to advocate for greater community acceptance of SRH education and services. The campaign should incorporate religious views and cultural perspectives, engage multisectoral champions (public male and female community role models) and ensure the community is provided with relevant knowledge and skills.
4. Use peer-based models to transfer positive SRHE knowledge and attitudes among children, adolescents and young people, and introduce digital innovations to deliver SRH messages (e.g. self-care digital tools).
5. Establish a comprehensive monitoring and evaluation mechanism prior to programme implementation to avoid ineffective efforts and to ensure efficient use of available resources.
6. Form a Task Force under the ACCRH to review the 2009-2012 PEKERTI document regarding its overall structure, comprehensiveness and length. Consider updating the rationale, objectives, target population and strategies; most appropriate timeframe; and ensure publication of an official English version to facilitate international engagement.

[249] Positive sexuality education approaches strive to achieve ideal experiences, rather than solely working to prevent negative experiences. They acknowledge and address the various concerns and risks associated with sexuality, without reinforcing fear, shame or taboo of young people's sexuality or gender inequality. For further details, refer to with concepts expanded in **Box 3**, extracted from UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

Appendix 1: 2009-12 PEKERTI National Policy and Plan of Action

This 9-page document covers the Policy (pages 1-3), which includes the policy statement, rationale, objectives, implementing strategies. The Plan of Action (pages 4-9) is presented as a table. For each of the 4 implementing strategies, the plan prescribes the strategy, program (in short and medium terms), the implementing agency, and the expected outcome.

POLICY STATEMENT: The National Reproductive and Social Health Education Policy that applies to all age demographics and aims at improving the knowledge on sexual reproductive health among Malaysian and encouraging positive attitudes towards reproductive and social services. Reproductive and social health education is fundamental to the development of strong and healthy human development and mutual respect. The policy incorporates the multicultural, multiethnic and multifaith diversity in Malaysia.

RATIONALE: The reproductive and social health education is a lifelong process for acquiring a comprehensive knowledge of biological, socio-cultural, psychological, and spiritual aspects towards healthy behaviors. This education and knowledge support the development of responsible individuals.

PEKERTI OBJECTIVES:

1. To raise awareness of the community about the importance of reproductive health and social education;
2. To develop expertise in reproductive health and social education among members of the community;
3. To enhance research and development to improve reproductive health and social education systems; and
4. To improve the effectiveness of implementing health and social education.

IMPLEMENTATION STRATEGY: To achieve the above objectives, strategies have been formulated based on four components including Advocacy, Human Capital Development, Research and Development, and Monitoring and Evaluation.

TARGET GROUPS FOR PEKERTI PROGAMME:

1. National Service Training Program (PLKN) trainees (this programme was discontinued in 2018)
2. School students (Primary, Secondary and special educational school)
3. Students in Institute of Higher Learning and College Student
4. Parents and the public, in which the program is absorbed in the Family Development Program and the Center for Family

Appendix 2: Technical Working Committee Membership

Technical Working Committee guiding the comparative study of reproductive and social health policies between Malaysia and Muslim countries

1. Chairman:

Deputy Director General (Policy), National Population and Family Development Board (LPPKN)

2. Members:

- Human Reproduction Division, LPPKN
- Population and Family Research Division, LPPKN
- Strategic Planning Division, LPPKN
- Policy and Strategic Planning Division, Ministry of Women, Family and Community Development (KPWKM)
- Ministry of Youth and Sports (KBS)
- Ministry of Health (KKM)
- Ministry of Education Malaysia (KPM)
- Ministry of Higher Education Malaysia (KPT)
- Department of Islamic Development (JAKIM)
- Institute of Higher Learning (IPTA)
- Economic Planning Unit (EPU)
- Legislative Unit, LPPKN
- United Nations Population Fund (UNFPA)
- Federation of Reproductive Health of Malaysia (FRHAM)
- And other related agencies

3. Secretariat

Human Reproduction Division, National Population and Family Development Board (LPPKN)

Appendix 3: Contextual information across selected Muslim countries

Table 9 Commitments to key international conventions/protocols relevant to reproductive rights and the right to sexuality education

International resolutions/frameworks related to family planning	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Universal Declaration of Human Rights, 1948	-	✓	✓	-	-
International Convention on the Elimination of All Forms of Racial Discrimination, 1965	-	✓	✓	✓	✓
International Covenant on Civil and Political Rights, 1966	-	✓	✓	✓	✓
International Covenant on Economic, Social and Cultural Rights, 1966	-	✓	✓	✓	✓
Alma Ata Declaration, 1978	✓	✓	✓	✓	✓
Convention on Elimination of All forms of Discrimination Against Women (CEDAW), 1979	✓	✓	✓	✓	✓
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984	-	✓	✓	✓	✓
Convention on the Rights of the Child, 1989	✓	✓	✓	✓	✓
Cairo Declaration on Human Rights in Islam, 1990	✓	✓	✓	✓	✓
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990	-	✓	✓	✓	✓
International Conference on Population and Development (ICPD), 1994	✓	✓	✓	✓	✓
Beijing Platform for Action (BPfA), 1995	✓	✓	✓	✓	✓
Millennium Development Goals (MDGs), 2000	✓	✓	✓	✓	✓
Convention against Transnational Organized Crime, 2000	✓	✓	✓	✓	✓
Protocol against the Smuggling of Migrants by Land, Sea and Air, 2000	-	✓	✓	-	-
Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, 2000	✓	✓	✓	✓	✓
Convention on the Rights of Persons with Disabilities, 2006	✓	✓	✓	✓	✓
International Convention for the Protection of All Persons from Enforced Disappearance, 2006	-	-	-	✓	-
Declaration on the Rights of Indigenous People, 2007	✓	✓	✓	-	-
2012 CRC-OP-SC - Optional Protocol to the Convention on the Rights of the Child on the sale of children child prostitution and child pornography	-	✓	✓	✓	✓
2012 CRC-OP-AC - Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	-	✓	✓	✓	✓
Sustainable Development Goals (SDG 3 and SDG 5), 2015	✓	✓	✓	✓	✓

Sources: Centre for Reproductive Rights (www.reproductiverights.org); United Nations (2014). Reproductive rights are human rights: A handbook for national human rights institutions; https://indicators.ohchr.org/ https://www.unodc.org/unodc/en/treaties/CTOC/signatures.html; https://www.refworld.org/docid/3ae6b3822c.html; https://www.ohchr.org/en/issues/ipeoples/pages/declaration.aspx

Table 10 Contextual information across selected countries (2018 data mostly) [250]

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Demography					
Country Income Level[251]	Upper Middle Income	Upper Middle Income	Low Middle Income	Low Middle Income	Low Middle Income
Religions	Secular state [252]: 63% Muslim (Sunni), 19% Buddhism, 10% Christian, 6% Hindu, 2% Other	Secular state: 99.8% Muslim (mostly Sunni), 0.2% Other	Islam state religion post 1980, 90% Muslim (mostly Sunni), 9% Coptic, 1% Other	Islam is state religion, 99% Muslim (Sunni)	Secular state but Islam is state religion. 89% Muslim (mostly Sunni), 11% Hindu, 1% Other
Total population (millions)	31.5 32.7 (2020) [253]	82.3	98.4	36.0	161.4
Total Fertility Rate (2018) [254,255]	2.0 (decreasing)	2.1 (decreasing)	3.3 (decreasing)	2.4 (decreasing)	2.0 (decreasing)
Population strategy	Encourage higher fertility	Encourage higher fertility[256]	Population control	Encourage higher fertility	Population control
Median age (years)	30.3	31.5	24.6	29.5	27.6
Population in millions (< 5 years)	2.6	6.7	13.0	3.4	14.5
Population in millions (ages 15-64 years)	21.9	55.1	60.0	23.7	108.3
Population in millions (≥-65 years)	9.6	7.0	5.1	2.5	8.3
% Urban population	76.0	75.1	42.7	62.5	36.6
Human Development Index (HDI) and rank out of 189 countries	0.804 (61)	0.806 (59)	0.700 (116)	0.676 (121)	0.614 (135)
Human Development Index (HDI), female	0.792	0.771	0.643	0.603	0.575
Human Development Index (HDI), male	0.815	0.834	0.732	0.724	0.642
Economic indicators					

[250] UN Human Development Programme (2020) Global Human Development Indicators.
[251] World Bank (2019) Country Income Levels.
[252] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[253] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[254] The World Bank (2018) Total Fertility Rate (births per woman).
[255] UN Department of Social Affairs (2020) World Fertility and Family Planning 2020: Highlights
[256] Yucesahin MM, Adali T, Turkyilmaz AS (2016) Population Policies in Turkey and Demographic Changes on a Social Map. Border Crossing 6:240–266
UNFPA (2016) Current overview of Turkey's population

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Gross National Income (GNI) per capita (2011 PPP $)	27,227	24,905	10,744	7,480	4,057
Gross Domestic Product (GDP) per capita (2011 PPP S)	28,176	25,287	11,014	7,509	3,879
Income index	0.847	0.833	0.706	0.652	0.559
Work, employment and vulnerability					
Employment to population ratio (% ages 15 and older)	62.4	46.8	42.6	41.3	56.2
Labour force participation rate (% ages 15 and older)	64.6	52.5	48.1	45.4	58.7
Labour force participation rate (% ages 15 and older), male	77.4	72.6	73.2	70.4	81.3
Labour force participation rate (% ages 15 and older), female	50.9 55.2 (2018) [257]	33.5	22.8	21.4	36.0
Unemployment, total (% of labour force)	3.4	10.9	11.4	9.0	4.3
Old-age pension recipients (% of statutory pension age population)	19.8	100.0	n.a.	39.8	33.4
Unemployment, youth (% ages 15–24)	11.2	20.0	32.6	21.9	12.0
Health indicators					
Health expenditure (% of GDP)	3.8	4.3	4.6	5.8	2.4
Life expectancy at birth (years)	76.0	77.4	71.8	76.5	72.3
Life expectancy at birth, males (years)	74.1	74.4	69.6	75.2	70.6
Life expectancy at birth, females (years)	78.2	80.3	74.2	77.7	74.3
HIV prevalence, adult (% ages 15-49)	0.4 Total 4,212 (12% ♀) (2018) [258]	n.a.	0.1	0.1	0.1
Mortality rate, infant (per 1,000 live births)	7.2[259]	10.0	18.8	20.0	26.9
Mortality rate < 5 years (per 100,000 live births)	8.8[260]	11.6	22.1	23.3	32.4
Gender indicators					
Gender development index (GDI)	0.972	0.924	0.878	0.833	0.895
Gender Inequality Index (GII) and rank out of 162 countries	0.274 (58)	0.305 (69)	0.450 (102)	0.492 (118)	0.536 (129)

[257] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[258] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[259] As advised by the MoH representative to the TWC
[260] As advised by the MoH representative to the TWC

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
Adolescent Fertility Rate (births per 1,000 women aged 15-19 years) (2018) [261]	12 (2015) 8.5(2018) [262]	26.6	53.8	31.0	82.0
Maternal mortality ratio (deaths per 100,000 live births)	23.8 (2015) 23.5 (2018) 22 (2019) [263]	16	33	121	176
Antenatal care coverage, at least one visit (%)	97.2	97.0	90.3	77.1	63.9
% of births attended by skilled health personnel	99.5	98.0	91.5	86.6	67.8
Child marriage, women married by age 18 (% of married women ages 20-24)	n.a.	15	17	13	59
Contraceptive prevalence, any method (% of married or in-union women ages 15-49)	52.2 (2014) [264]	73.5	58.5	70.8	62.3
Contraceptive prevalence, modern method (% of married or in-union women ages 15-49)	34.3 (2014) [265]	n.a.	n.a.	n.a.	n.a.
Unmet need for family planning (% of married or in-union women ages 15-49 years)	19.6% (2014) [266]	5.9	12.6	13	12.0
Proportion of demand satisfied with modern methods for age group 15-49	58 (2016)[267]	n.a.	n.a.	n.a.	n.a.
Prevalence of female genital mutilation/cutting among girls and women (% of girls and young women ages 15-49)	n.a.	n.a.	87.2	n.a.	n.a.
Violence against women ever experienced, intimate partner (% of female population ages 15 and older)	n.a.	38.0	25.6	n.a.	54.2
SDG Indicator 5.2.1. % of ever-partnered women aged ≥ 15 years experiencing physical or sexual violence from an intimate partner in the previous 12 months [268]	27%	34.5%	39.5%	39.4%	44.5%
Violence against women ever experienced, non-intimate partner (% of female population ages 15 and older)	n.a.	n.a.	n.a.	n.a.	3.0
Education indicators					
Education index	0.713	0.712	0.608	0.547	0.513
Government expenditure on education (% of GDP)	4.7	4.3	n.a.	n.a.	1.5

[261] The World Bank (2018) Adolescent fertility rate (births per 1,000 women ages 15-19)
[262] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[263] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[264] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[265] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[266] LPPKN (2016) Fifth Malaysian Population and Family Survey 2014 - Report on Key findings
[267] ARROW (2018) National Report: Malaysia – Child Marriage: Its Relationship with Religion, Culture and Patriarchy
[268] Global Burden of Disease Collaborative Network (2017) Global Burden of Disease Study 2016 (GBD 2016) Health-related Sustainable Development Goals (SDG) Indicators 1990-2030. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), quote in (2016) Goal 5: Gender Equality - SDG Tracker. In: Our World in Data.

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
	4.2 (2017) [269]				
Expected years of schooling (years)	13.5	16.4	13.1	13.1	11.2
Expected years of schooling, male (years)	13.1	16.9	13.1	13.6	10.8
Expected years of schooling, female (years)	13.8	15.9	13.1	12.6	11.6
Mean years of schooling (years)	10.2	7.7	7.3	5.5	6.1
Mean years of schooling, male (years)	10.3	8.4	8.0	6.4	6.8
Mean years of schooling, female (years)	10.0	6.9	6.7	4.6	5.3
Gross enrolment ratio, pre-primary (% of preschool-age children)	97	30	29	54	40
Gross enrolment ratio, primary (% of preschool-age children)	103	101	105	112	111
Gross enrolment ratio, secondary (% of secondary school-age population)	86	103	86	80	67
Gross enrolment ratio, tertiary (% of tertiary school-age population)	42	104	34	34	18
Literacy rate, adult (% ages 15 and older)	93.7 96.3 (2018) [270]	96.2	71.2	69.4	72.9
% of primary schools with access to the internet	100 [271]	n.a.	48	79	4
% of secondary schools with access to the internet	100 [272]	n.a.	49	89	82
Population with at least some secondary education (% ages 25 and older)	80.8	53.1	65.3	32.2	46.7
Population with at least some secondary education, male (% ages 25 and older)	81.8	66.0	71.2	35.6	49.2
Population with at least some secondary education, female (% ages 25 and older)	79.8	44.3	59.2	29.0	45.3
Primary school teachers trained to teach (%)	99	n.a.	74	100	50
Primary school dropout rate (% of primary school cohort)	3.6	12.0	3.6	4.9	33.8
Inequality indicators					
Inequality in education (%)	12.1	16.5	38.1	n.a.	37.7
Inequality-adjusted education index	0.627	0.594	0.376	n.a.	0.320
Inequality in income (%)	n.a.	22.6	36.5	21.7	15.7
Inequality in life expectancy (%)	6.1	9.0	11.6	13.0	17.3
Mobility and communication indicators					
Internet users, total (% of population)	81.2	71.0	46.9	64.8	15.0

[269] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[270] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[271] United Nations Development Programme (UNDP) 2020 Human Development Indicators. Based on information provided by the MoE representative within the TWC, internet coverage might be limited in schools located in rural and remote areas.
[272] United Nations Development Programme (UNDP) 2020 Human Development Indicators. Based on information provided by the MoE representative within the TWC, internet coverage might be limited in schools located in rural and remote areas.

Demographics	Malaysia	Turkey	Egypt	Morocco	Bangladesh
International student mobility (% of total tertiary enrolment)	2.9	0.6	0.7	-2.8	-1.2
Internet users, female (% of female population)	78.7 (59% ♂; 41% ♀) (2018) [273]	63.9	41.3	61.1	n.a.
Mobile phone subscriptions (per 100 people)	134.5	97.3	95.3	124.2	97.3
% of mobile phone ownership by sex, 2018	(59% ♂; 41% ♀) (2018) [274]	n.a.	n.a.	n.a.	n.a.

[273] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains
[274] Department of Statistics, Malaysia (2019) Statistics on Women empowerment in selected domains

Appendix 4: Summary of Malaysian studies assessing the existing PEERS curriculum

Table 11 Summary of Malaysian studies assessing the existing PEERS curriculum

Study type	Study participants	Findings	Conclusions and Recommendations
A 2012 cross-sectional evaluation of PEERS against UNESCO's curriculum guidelines[275]	380 university participants and former PEERS students aged 20-23 years (60.5% females)	• After been shown UNESCO's CSE curriculum, 95% of participants thought that sex education was not taught in school formally. On further prompting, 85% reported that sexuality education was held in schools but only in limited basis and not clear, and 5% reported it was done informally. Only 5% stated that their teachers taught on sex education clearly. • Participants highlighted the limited depth of the school content and described it as unclear and fragmented, and teachers used metaphors which confused students. For instance, science teachers taught the development of the reproductive system and fertility processes without linking it to sexual relationships, values and responsibilities; female religious teachers emphasised the boundaries between men and women, morality and the importance of husband and wife relationships without empowering girls to navigate through unequal power relations.	• **CSE is not taught in classes across the nation according to UNESCO's curriculum guidelines.** A few topics relating to the reproduction system's development, the fertilisation process, the relationship between men and women and an Islamic interpretation of sex are integrated within the Science and Islamic Education subjects. Based on the topics, what is learnt by the students is not actually CSE, but simply a few related topics taught by teachers to fulfil the needs of an examination-oriented system. • CSE should incorporate topics relating to the physical development of a child to his/her adolescence, the reproduction system, sexual intercourse and childbirth, pregnancy control, judging sexual advances from men or women and preventing STIs and illicit sex. • **Nearly 90% of respondents agree that sex education should be implemented in Malaysian schools with meticulous planning, starting with students in Form 3 and being taught in separate classes for boys and girls respectively while relating the Islamic perspective.**
A 2012 cross-sectional survey, using an anonymous self-administered survey. [276]	1,695 female Malaysian university students and former PEERS students in a public university in Malaysia.	• Respondents had low scores for knowledge of reproduction and pregnancy (median = 4 out of a maximum score of 10), contraceptive uses (median 6/16) and contraceptive availability (median 3/13), particularly for those of Malay Muslim ethnicity. • Most respondents had conservative values regarding premarital sexual behaviour (median=37/40 with higher scores corresponding to opposing premarital sex). • Multivariate analyses showed that ethnic group was the strongest correlate of knowledge and attitude scores; being of Malay Muslim ethnicity was significantly associated with lower knowledge scores and premarital sex permissiveness. Level of premarital sex permissiveness was inversely correlated with reproduction and pregnancy knowledge score, and contraceptive knowledge scores.	• **Reproductive health knowledge was low and linked to religious values and cultural norms differences about sexual issues.** • Knowledge disparities were closely linked to ethnic, social, economic and parental factors. Greater knowledge about reproduction, pregnancy and contraception were not associated with more permissive values on premarital sexual behaviours. • The main practical implication is that **reproductive health education should include appropriate teaching about pregnancy prevention, and how to use and to obtain contraception.**

[275] Talib J, Mamat M, Ibrahim M, Mohamad Z (2012) Analysis on Sex Education in Schools Across Malaysia. Social and Behavioral Sciences 340–348

[276] Wong LP (2012) An exploration of knowledge, attitudes and behaviours of young multiethnic Muslim-majority society in Malaysia in relation to reproductive and premarital sexual practices. BMC Public Health 12:865.

Study type	Study participants	Findings	Conclusions and Recommendations
		• While there was good awareness of contraceptive types, there knowledge in how to use contraception and where to obtain contraceptives was limited, which likely contributes to the non-use of contraception during first sexual intercourse or inconsistent use among those in a relationship.	
A 2012 UNPFA commissioned review including Focus Group Discussions with young people [277]		• The current sexual and reproductive health curriculum was developed by the Ministry of Education for implementation in schools. However, the documents supporting the implantation were found to be unclear. These included the guidelines for the schools and teachers such as lesson plans, who are responsible to teach the subject, how the subject is to be incorporated it into the current timetable, the mode of delivery, for example, or whether the subject should be addressed via knowledge-based models or via interactive and skills-based modes of learning. • It is unsure whether sex or reproductive health education is taught in school because the current curricula is already crowded and the subject is not an examination subject. • No reward is being awarded to schools which have the best SRH educated students. There is also no detail feedback from schools and teachers who taught the subject and students who attended the classes. • Focus group discussions with young people revealed that young people would like to have more SRH knowledge but are unable to get it from school. Many of them would rather SRH be taught by teachers than parents. • The content and implementation of sexuality education in schools was inadequate and fragmented, which led to teachers either avoiding it or addressing it ineffectively. Teachers felt uncomfortable with teaching sexuality education due to inadequacies in their own training and limited support, school leadership and commitment.	• **The impact of the training and educational programmes conducted by LPPKN for the young people in the schools and national service trainees had not been systematically evaluated** in terms of quality or effectiveness at the time the report was written, as the programmes were new. **It is critical to have a monitoring and evaluation (M&E) plan in place prior to the implementation**. • However, **informal feedback from students participating in the programmes was generally positive** and girls and boys appreciated the opportunity to explore sexual matters in a safe space. **Young people were receiving more explicit information rather than learning more life skills.** • Coverage the young people training programmes conducted by NGOs (such as FRHAM) may be limited human and funding resources. **In general, the needs of the out-of-school youths are poorly met.** Only FRHAM provides some SRH and HIV information for the young people in juvenile homes and is dependent on availability of funds from funding agencies like UNFPA. • **The is no specific programme to meet the SRH needs of young people marginalised due to the non-conforming sexual orientation** except for PT Foundation and Safe Clinic whose coverage is only in the Klang valley and they provide mainly HIV related information.
A 2013 cross-sectional survey, using an anonymous	1,706 university students (1,180 female) and former PEERS students across	• Participants had low content recall for taught sexuality education (lowest for STIs, human relationships, negotiation skills and masturbation, and highest for human anatomy and general biological functions).	• Malaysian young people had received a form of sex education while in school and they require more in-depth information on this topic. Although PEERS has been in schools since 1989, **just two-thirds of**

[277] Huang (2012) Addressing the unmet need for family planning among the young people in Malaysia. UNFPA-ICOMP Workshop on Operationalizing the Call for Elimination of Unmet Need for Family Planning in Asia and the Pacific Region

Study type	Study participants	Findings	Conclusions and Recommendations
self-administered survey[278]	three universities in the Klang Valley	• 69% recalled having had learnt about sexual and reproductive systems followed by puberty (65%) and the least (58.8%) on the relationship with the opposite sex. • Significant gender differences were found for recalling on the topic of puberty, where 11% more female reported this compared to their male counterparts ($p<0.01$). Significant differences were also found between ethnicities for recalling topics. Recall for *sexual and reproductive system* (70% for Malays; 63% for Chinese and 52% for Indians) was better than for *relationship* (62% for Malays; 52% for Chinese and 32% for Indians) • Most respondents reported that they would like more information with regards to *Biology of reproduction* (detailed description of female and male genitalia, explanation of bodily developments during puberty and menstruation) and *STIs*. • More Malays wanted more information on *STIs* and *HIV/AIDS* relative to Indians. The Chinese wanted more information on *sexual desire and pleasure* and *negotiating sex with partner* than Indians.	**respondents recalled learning about puberty, sexual and reproductive system, and relationship with the opposite sex.** • Most respondents were unaware about SE being taught to them while in class. This somewhat reflects that the information retention was less effective in the current integrated curriculum. • Although components of CSE were being integrated within the school system, **a significant gap remains in content and delivery which should be addressed via curriculum revision, teachers training and delivery methods to improve information retention to provide effective CSE.**
A 2017 literature review [279]		• Sexuality education has been implemented in Malaysia for a decade via a disintegrated and fragmented approach, leaving most adolescents with inadequate knowledge about sexuality and making them vulnerable to abuses, STIs and unintended pregnancy. • The content is limited to knowledge on sexuality and reproductive health, promoting abstinence and curbing what is perceived as moral transgressions such as premarital sex and its consequences. • Implementation barriers include misconception on the impact of sexuality education, disagreement on the curriculum, lack of availability of trained teachers or trainers, lack of family and parents' involvement and poor multidisciplinary collaboration.	The review recommended **multisectoral stakeholder collaboration to adapt content from international guidelines and human rights standards to Malaysia's multiracial and multifaith society and bridge gaps in its delivery by improving the training for teachers**.

[278] Mokhtar MM, Rosenthal DA, Hocking JS, Satar NA (2013) Bridging the Gap: Malaysian Youths and the Pedagogy of School-based Sexual Health Education. Procedia - Social and Behavioral Sciences 85:236–245.
[279] Razali S (2017) Are Malaysians ready for comprehensive sexuality education? Journal of Advanced Research in Social and Behavioural Sciences 9:14–28

Study type	Study participants	Findings	Conclusions and Recommendations
A 2018 comprehensive review assessing implementation of CSE in Malaysia by ARROW [280]	Desk review of relevant documents and policies	• Barriers to CSE progress include an abstinence-based curriculum, untrained teachers, and the lack of parental and family support, political willpower and a robust monitoring and evaluation mechanism. • More need to be done to address STIs, unwanted teenage pregnancies, sexual violence and child sexual grooming to achieve progress towards the SDGs, particularly quality education and gender equality, and the ICPD PoA priority actions.	• The review calls for the implementation of **more inclusive, comprehensive, engaging and effective interventions that meet the needs of Malaysian unmarried young people to improve sexuality education and link it with available SRH services** staffed with trained health professionals to better inform the young people, particularly the marginalised ones in the spirit of leaving no one behind.
	In-depth Interviews with key informants from MOE, MOH, LPPKN and NUTP	Key informants agreed that the implementation of sex education has progressed far since its introduction in 1989. PEERS is perceived as well-received, comprehensive and relevant Teachers still feel uncomfortable to teach subjects related to SE because they feel like they have not received sufficient training. **Informants agreed that the PEERS curriculum and all other LPPKN and MoH programmes are abstinence-only programmes believed to be suitable to the Malaysian culture.** LPPKN stated that their programmes in schools are carried out with the general assumption that all the students are not sexually active. SE is centred towards adolescents with high risk sexual behaviour A key informant noted that there is nothing comprehensive about the SE implemented in Malaysia; both in terms of reach and content.	• **A multi-sectoral approach is needed to ensure the effective implementation of CSE for in- and out-of-schools adolescents**. • **Abstinence-only education is not sufficient to address the SRHR contemporary needs of young people**. • **Existing programmes may not reach all young demographics**, disadvantaging particularly those in rural areas and those out of the school system. • **All respective ministries/agencies interviewed were contributing towards the implementation of SE in Malaysia via several modules** providing SE to young people and other groups of population. LPPKN noted that modules such as Modul Cakna Diri (adolescents and parents edition) and SRH Module for Boys (16-24) were developed and used in their SE programmes. Modules such as *Adolescent Secret and Adolescent Searching for Love* developed by MoE, were used in MoH's SE programmes. MoH also reaches young people via their PROSTAR school programme. • However, participants acknowledged **a need for one agency to consolidate the efforts made by various agencies and champion the cause on CSE implementation in Malaysia.**
	14 Focus Group Discussions (FGDs) with 104 adolescents aged 15-19 years schools from school, juvenile rehabilitation centres and a halfway	FGDs with adolescents noted limited understanding of CSE (misconceptions) and PEERS, poor recall of topic coverage, reciving abstinence-only sex education, sex as a taboo topic for girls; limited understanding of gender as a biological attribute; ignorance towards adolescent RHR needs; misconception about accessibility to SRH services and fear of discrimination; contraception knowledge alone is not sufficient to prevent unprotected sex; need for information on STIs and early signs of	• The current curriculum is abstinence and fear based and focus on the reproductive system. **A comprehensive revision of the PEERS curriculum should take place, incorporating key elements of gender, sexual rights, pleasure, diversity and HIV prevention.** • Involve students, teachers and parents in the development of the curriculum • Varying teaching methods and the integration of SE topics into various subjects may impact the low recall of topic coverage.

[280] ARROW (2018) Comprehensive Sexuality Education for Malaysian Adolescents: How Far Have We Come?

Study type	Study participants	Findings	Conclusions and Recommendations
	home for pregnant girls (64% females)	pregnancy; use of electronic platforms to access pornography; contradicting roles played by parents: educator vs. moral police	
	FGDs with 29 parents and teachers	FGDs noted that PEERS is view as SE but there is a limited understanding of CSE. Sex is a taboo topic and highly sensitive, and SE should be culturally and religiously sensitive; **abstinence only is considered most appropriate to be taught in schools and the current curriculum highlights the negative outcomes of sex to instill fear of STIs, pregnancy and abortion**; teachers claimed that only 10%-20% of the entire syllabus is allocated to SE in a year; 70% of adolescent learn about sexuality from social media and 30% from school; teachers fear being misinterpreted and experience a lack of resources and lack of PEERS training, which makes them uncomfortable teaching SE; all participants agreed that SE subject experts should be included in the school system for more accurate precise and complete SE information; gender is seen as biologically determined and **that the curriculum should incorporate a broader coverage of gender, including non-confirming gender roles to identify students needing special counseling, religious bodies or special health facilities *for rehabilitation and transformation.*** Parents were concerned about children's development and noted schools/teachers can improve the SRH knowledge and skills. Teachers noted that parents should be more involved.	• Experts should be included in the school system for more accurate precise and complete SE information • Use innovative digital technologies to reach young people • Improve training and support for teachers • Engage parents in the teaching

Appendix 5: Summary of recommendations based on the evidence for TWC's consideration

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
1. **Establish comprehensive collaboration and policies**					
Limited coordination and collaboration across key agencies - Most adolescent policies either overlook the sexualityeducation and services needs of adolescents, with the exception of the *2006-20 National Adolescent Health Plan of Action*, which identified SRH as a priority area and mainly know to MoH's clinics and hospitals. - The 2009-12 National Reproductive Health and Social Education Plan of Action did not specify the extent to which SHR education and services would be made available to the unmarried young people.	Revive the Advisory and Coordinating Committee for Reproductive Health (ACCRH), overseen by LPPKN, to improve the quality of reproductive and sexual health education by increasing multisectoral collaboration and coordination (involving governmental, NGO and private partnerships, referred to as 3Ps for public, private and partnerships), overseeing the implementation of the 2020-24 National Reproductive and Social Health Education Plan of Action across age groups (commencing from age 5), and integrating sexuality education and service delivery (e.g. consider FRHAM's expertise in rolling out teachers' training). • **ACCRH membership to include at least one champion from young people, teachers, parents, religious and community leaders, and health professionals from different ethnic groups** (to ensure inclusivity) as well as Government agencies and NGOs • Train ACCRH members in gender mainstreaming of programmes and monitoring of gender indicators. • The ACCRH role: - Oversee the planning, implementation, and M&E of the *2020-24 National Reproductive and*	Coordination and collaboration across key agencies is critical to advance and sustain SRH programs, share expertise, experiences and lessons learn in implementing SRH programmes and services, avoid duplication and inefficiency, and support creativity and innovation. *Rationale for membership:* young people's and other voices should be given a platform to incorporate their concerns and suggestions regarding sexuality education and services to address their needs, understand the causes being championed and the implications of these reforms and increase commitment at the grass root level (schools, teachers, service providers, programme personnel).	- ACCRH in working order with supporting documentation including membership and specific roles and responsibilities, clear decision-making processes, and a convening schedule and secretariat led by LPPKN - ACCRH to develop a Monitoring and Evaluation (M&E) plan for the PoA prior to its implementation.	- ACCRH to develop clear guidelines on provision of sexuality education and services - Full implementation of rights-based, informed choice CSE for young people that practices meaningful participation - Policy reforms likely to improve the lives of Malaysian young people (e.g. the minimum age of marriage in Malaysia should align with international standards and be set to 18 years for all legal frameworks, including civil, Muslim and native customary laws without exceptions).	LPPKN (MWFCD) MoH MoE NGOs Representatives from young people, teachers, parents, religious and community leaders and health professionals from different ethnic groups

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
	Social Health Education Plan of Action to address key priorities - Integrate sexuality education and service delivery and increase multisectoral collaboration and coordination across key stakeholders - Oversee and validate the adaptation of CSE curriculum to the Malaysia's multiracial and multifaith context based on human rights - Specify the extent to which SHR education and services would be made available to the unmarried young people (ensure inclusivity) - Advocate to strengthen CSE related laws, policies and frameworks for young Malaysians.				
2. Improve the sexuality education curriculum and programmes and their delivery					
The PEERS curriculum promotes abstinence-only based misconceptions that CSE encourages promiscuity • content limited to sexuality and reproductive health, excludes safer sex and contraception, instills fear of sexuality and STIs, pregnancy and abortion • does not align with UNESCO's curriculum guidelines. • lacks the CSE right-based and gender-focused principles	**Improve and align content of SRHE with international best practice** • Adapt international guidelines to Malaysia's multiracial and multifaith society by incorporating four CSE components: rights, participation and agency; sexual and reproductive health and behaviours; gender equality and power; and positive sexualities and respectful relations • Include right-based and gender-focused principles both in school and community programmes to empower young people in making informed decisions about sex and sexual behaviours.[281]	• Despite the PEERS curriculum, the 2014 Malaysian Population and Family Survey and other Malaysian studies revealed that SRH knowledge among adolescents is very limited • Barriers in further reductions in AFR include the limited sexuality education and contraceptive practice, indicating the urgent need to incorporate a women empowerment component • Strengthening young people's psychosocial competence is likely to protect them from risky sexual behaviors. Consider adding:	- A rights-based, and gender focused curriculum delivered as a stand-alone subject or as part of other subjects incorporating key elements: gender, SRH and HIV, sexual rights and sexual citizenship, pleasure, violence, diversity and relationships. **Up-scale sexuality education programmes** - Develop policy guidelines and detailed plan of action that is explicitly linked to education sector plans, as well as to other national	- A Comprehensive Sexuality Education (CSE) curriculum that is culturally appropriate - Number of schools implementing CSE at national, state and district levels	MoE MoHE

[281] UNFPA (2014) UNFPA Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
• lack of parents' acceptance and engagement • Public health concerns related the consequences of premarital and unprotected sex which disproportionately affect girls (STIs and HIV/AIDS, unintended teenage pregnancy, unsafe abortion and baby abandonment) • In 2018 there was a reduction in the number of schools participating in the PEKERTI @ Schools program due to budget constraints.	• Refer to WHO's *Core Global Indicator Framework* when developing curriculum content and for its M&E, highly relevant for addressing unintended pregnancy.[282] • Content should be developmentally and age appropriate and more visual with illustrations, making the lessons more effective (as in Bangladesh) • Engage and collaborate with young people, parents and teachers in developing the curriculum to ensure its relevance • Health experts should be included in the school system for more accurate precise and complete SE information • MoE to ensure district level teachers receive CSE trainings to delivery of the curriculum.	- Comprehensive reproduction and pubertal changes - Appropriate explanation of sexual intercourse, safe sex and the use of contraception aligned with local norms, values and culture (how to use and where to get contraceptives, a complete definition of abstinence) - Empowerment and gender equality, covering the consequences of unequal power dynamics and toxic masculinities and how to address them), healthy relationships and negotiating non-violent solutions, personal safety measures, and consent, SRH rights and sexual diversity	strategic plans and policy frameworks on young people SRH. - Circulate it to the schools; support implementation of sexuality education programs; address sensitivities concerning the implementation of sexuality education programs; and protect and support teachers responsible for delivery of sexuality education.		
Poor implementation of sexuality education curriculum in schools • Significant gap in content and delivery • Shortage of teachers trained in sexuality education and services • Teachers felt uncomfortable delivering the curriculum due to shortcomings in their own training, support, school	**Improve and align delivery of SRHE with international best practice** • Improve teachers training, delivery methods (use a participatory teaching approach) and ongoing support • Use a participatory teaching approach that encourages dialogue, conveys positive views of sexuality and does not rely on shame/fear based strategies.	• The effectiveness of the teachers depended on the strategy and method of teaching used by the teachers. • The delivery mode is extremely important to increase the schools' commitment, develop the teachers' skills and build their comfort and confidence in delivering sexuality education. • A participatory teaching approach allowing the students to ask	• Establish an M&E mechanism to assess both student knowledge and teachers' performance. • Develop implementation plans such as how to select and train teachers who are responsible to teach the subject, lesson plans, number of hours, how the subject is to be incorporated it into the current timetable,	• Assessment of students' knowledge attitudes, beliefs and behaviours pre and post-delivery • Assessment of teachers' knowledge attitudes, beliefs and behaviours pre and post-delivery and assessment of the training modules and	MoE MoHE

[282] UNESCO (2015) Emerging evidence, lessons and practice in comprehensive sexuality education: a global review

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
leadership and commitment, so they either avoid it or address it ineffectively • delivered in unclear and fragmented across subjects, not examined, which leads to teachers either avoiding or addressing it ineffectively (teachers use of metaphors causes confusion) • leads to poor student recall of reproduction and pregnancy, contraceptive uses and contraceptive availability, particularly Malay Muslim females, increasing their vulnerability to abuses, STIs and unintended pregnancy. • lack of parental support and engagement • students would rather SRH be taught by teachers than by parents • lack of systematic evaluation in terms of quality and effectiveness • MoE believes that sexuality education would be best practiced once it considers the context, religion and culture of pupils.	• Capacitate teachers and parents with accessible sexuality education module • Improve connectedness between parents and school by engaging parents with school-based sexuality program • Consider involving the NGOs (FRHAM) in the training of school teachers. • Consider involving trained young doctors and school health nurses (more acceptable information sources) in delivering SRH seminars to link sexuality education and services • Consider integrating the curriculum into one compulsory and examinable subject, for teachers and students to take the subject seriously. • Strengthen the monitoring mechanism within the education system, from the national level *Training of Trainers* to curriculum teaching in schools.	questions has been proven successful in increasing students' recall and influencing networks	the mode of delivery, provision of resources (including materials). • Create a team to develop and implement sexuality education specific indicators at national and state levels • Create a young people team to ensure their meaningful participation in M&E activities at national, state and district levels.	school's commitment and support • Assessment of parents' knowledge attitudes, beliefs and behaviours pre and post-delivery and assessment of support to students Suggested indicators for outcomes[283]: • % of young people who participate in CSE • %of CSE participants who demonstrate critical thinking • Reported changes in knowledge about: safer sex and transmission of HIV; accessing and using contraception, human rights • Reported changes in attitudes on: gender norms; girls' sense of agency and greater intent to delay pregnancy; boys' beliefs regarding traditional gender roles and stereotypes; respect for human rights, including the	

[283] Extracted from UNFPA (2014) Operational Guidance for Comprehensive Sexuality Education: A Focus on Human Rights and Gender

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
				rights of people living with HIV; tolerance of sexual diversity; sense of connectedness to school; perception of power balance in intimate heterosexual relationships • Reported changes in behaviour: delay in sexual initiation; increase use of male or female condom, contraception; decrease in experience or perpetration of sexual coercion and intimate partner violence; girls' participation in social/safe spaces programmes; boys' participation in exercises that help them to reflect on norms/expectations and self-perception; positive interactions with mentors	
Lack of parental engagement	• Engage parents in the teaching and learning processes to get their support to ensure that the information being taught at schools can be reinforced in the family home.	Parents/guardians/caretakers must understand the SRHE lesson plan to be delivered to adolescents, participate in their homework and assignments, and be encouraged to speak to their children about SRHE.	(i) Increase parent and family engagement in providing CSE to young people (ii) Encourage healthy parent-child relationship and communication (iii) Increase school-parent connectedness	- Development of programmes /information bank - Number of schools carrying out the programmes	MWFCD/NPFDB

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
The needs of out-of-school vulnerable youth are generally poorly meet • Limited coverage of youth friendly sexuality education and services via Youth Health Services by FRHAM targeted to **married and unmarried vulnerable young people** due to limited human and financial resources and funded by donors such as UNFPA. • Uneven geographic coverage of adolescent SRH programs concentrated in urban areas • No specific programme meets the SRH needs of young people marginalised for their non-conforming sexual orientation except for PT Foundation and Safe Clinic providing HIV-related information in the Klang Valley. • Gender diverse adolescents avoid using the SRH services due to fear of identity exposure, increasing the risk for physical and mental health issues such as contracting STI and HIV.	• Consider governmental financial support for LPPKN and FRHAM to scale-up the delivery of the out-of-school SRH programme • Ensure that programmes reach the ground level (such as districts and rural schools) • Focus on investing in programmes that are far reaching and will improve the lives of young people. • Analyses of national indicators and documentation of adolescent SRH needs should inform future investments on geographical areas and regions with greatest SRH needs. • Lessons from implementing CSE in Bangladesh & Egypt: Engage trained peers	- FRHAM is the only NGO providing SRH and family planning services either free or cheaply via its Youth Health Services at the state level with funding from international donors • several out-of-school sexuality educational programmes are delivered by LPPKN and FRHAM via information, education and communication (IEC) materials and adolescent SRH training modules (including family planning and HIV).	• A government budget line to support NGOs in delivering out-of-school youth programmes • Increase coverage of rural areas, and vulnerable young people (particularly those with non-conforming sexual orientation) in the spirit of leaving no one behind	- A funding budget across the duration of the strategy (2020-24) to support out-of-school sexuality educational programmes	LPPKN FRHAM
3. Run a mass media campaign to advocate for greater community acceptance of sexuality education and services					
Lack of media advocacy and a community communication plan	• Generate greater public awareness, desensitise the issue and generate open discussion on sexuality education and services	• Most adults are reluctant to give adolescents accurate sexual information for fear of promoting early sexual activity but accurate	• **Develop a structured communication plan, with messages that engage men**	• Improvement in community knowledge, attitudes, believes and	LPPKN

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
• Barriers to addressing young people's SRH needs included strong religious sensitivity and socio-cultural taboo attached to sexuality, with a very narrow learning scope from parents, guardians, elders and peers due to conservativeness rooted in the culture.	• A more pro-active stand from government to engage the media in conveying the need for and the positive impact of sexuality education for young people's health and well-being • Prioritise awareness raising of the benefits of family planning for families and communities linked to family planning services referrals • Consider referring to the Social and Behavior Change Communication (SBCC): Guide to Designing Sexual and Reproductive Health Programs for Youth in Egypt [284] when designing a SBCC plan for Malaysia. • Produce fact-based, age-appropriate educational resources, including textbooks, handouts and videos and websites	and comprehensive sexuality education will empower young people, reduce unwanted pregnancies, unsafe abortions, STIs and enable their health and well-being • Creating an enabling environment prior to implementing CSE is critical, including involving local religious leaders • Addressing young people's SRH requires multi-sectorial interventions that involve government agencies, civil society, religious institutions, mass media, as well as parents.	**& boys as well as girls and women.** • Resources and outcomes of evidence-based research, programmes and services should be widely disseminated via mass media • Multidisciplinary effort required government, policy maker, educationists, health professionals, experts in religion, social activists, NGOs urgent need to train implementers (e.g., teachers and social workers) and parents to enhance the effectiveness of sex education programs	behaviours (measured via pre and post campaign surveys)	
4. Improve SRH service awareness, delivery and accessibility					
Poor uptake of available SHR information and services due to lack of awareness or discrimination from health care providers • barriers exist due to conservative community views, which limit the provision of SRH services (including contraceptives or	• Improve universal equitable access and use of quality family planning services by focusing on vulnerable populations • Support data collection for family planning resource allocations • SRH (contraception) information and services should be made available to adolescents regardless of their marital status	• *Rationale:* It is critical that sexual and reproductive health services and education are integrated. • SRH services to focus on availability, accessibility, quality and accountability, including a universal access to rights, accounting for diverse contexts that affect women access that compromise their right	• Uptake of adolescent friendly health centers will likely improve as result of awareness raining and transforming beliefs and behaviours • Initiatives addressing some of these challenges started being implemented:	- Increased uptake of Youth Health Services	MoH

[284] Johns Hopkins Center for Communication Programs (2017) Social and Behavior Change Communication: Guide to Designing Sexual and Reproductive Health Programs for Youth in Egypt

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
STIs services) to married adolescents. • adolescents considered SRH services and providers disrespectful, lacking privacy and confidentiality, and judgmental. • Non-clinical services are more likely to be utilised by unmarried adolescents than clinical services. • Sexuality education programmes are not linked to services • it is generally assumed that the government does not provide contraceptive services to unmarried young people • however, married and unmarried pregnant women access perinatal services at health facilities • healthcare facilities may not be able to provide accurate and complete information to women who may seek abortion services.	• Improve integration of SRH services within the primary health care system • Develop an effective referral system to ensure young people are referred to appropriate SRH services, care and support • Review the 2009 MoH training sessions on adolescent SRH and counselling for health professionals, to deliver services in a professional, non-judgmental manner and address young people's needs including abortion laws and exceptions • Collection and report service access and legal abortion statistics to inform the proper allocation of resources to prevent further negative social consequences. • Review policy and laws that require parental consent for accessing the services to ensure that SRH services are available to adolescents safely and confidentiality. • Consider preplacing the vertical, one-size fits-all family planning service delivery model to differential approaches to address the needs of specific population groups (regional service packages including behaviour communication change and service delivery components, focusing on low-performing regions and pockets of hard-to-reach where service coverage is low and the disadvantaged urban. Evaluate	• Focus on vulnerable populations (young people, women/girls vulnerable to unwanted pregnancies, Orang Asli, migrant workers, disadvantaged rural areas, people with HIV/AIDS, GBV survivors) • Raising young people's awareness of family planning benefits for themselves, their families, and communities as a priority targeting both boys and girls.	Malaysia started universal access to SRH services for all adolescents in primary, secondary and tertiary healthcare facilities nationwide in 2012. MoH led provision of SRH services for both married and unmarried adolescents, by issuing the *2012 Guidelines on Managing Adolescents SRH Issues in Health Clinics* to support Youth Health Services, but uptake is poor.		

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
	ongoing programs and scape-up effective ones				
	Delivery of Youth Friendly Services (YFS) to provide SRH including family planning services which young people trust and feel is there for them and their needs - Assess the existing services to identify and address barriers - Develop National Operational Guideline for YFS for service providers to ensure quality and be used as an M&E tool **- Improve the delivery of youth friendly services according to IPPF's guidelines**: • Train providers to deliver SRH services in a sensitive and respectfully manner • Maintain privacy and confidentiality • Convenient clinic opening hours for young people (evenings and weekends) • Accessible to all young people regardless their age, marital status, ethnicity, religion, sexual orientation or ability to pay • Establish an effective referral system • Involve young people in designing, implementing and evaluating the program • Engage key stakeholders in the local community, such as partners, parents/guardians and schools	• improve publicity of clinics in the community, particularly increase acceptance among parents	- Government clinics to work closely with NGOs and youth peer educators in promoting their services. - NGOs can refer their young people clients for the services and youth peer educators can spread the news about the availability of the services among their peers.		FRHAM

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
5. Establish comprehensive monitoring and evaluation mechanisms					
Limited comprehensive, integrated and up to date SRH data to inform planning National data sources with large time gaps - The National Study on Reproductive Health and Sexuality of Adolescents is conducted by LPPKN every decade and collects limited data. - The Malaysian Population and Family Survey captures limited SRH data among Malaysian young people - Small scale studies vary in geography, coverage, focus, and age range: • National Surveys from the Department of Statistics, Malaysia; Global School-based Student Health Survey Malaysia 2012's fact sheet; 2015 Malaysian Youth Sexual and Reproductive Health Survey	**National data on young people's sexuality and reproductive health and family planning needs** - More regular surveys capturing comprehensive SRH information (*refer to the SYPE survey in Egypt*) on **married and unmarried** young people to measure trends and change in knowledge, attitudes, sexual practices (such as safe sex and use of family planning methods, human reproduction, relationships, HIV/AIDS and other STIs). - Conduct quality in-depth studies to improve interventions. All research to be coordinated to avoid duplication. Share research findings via regular conference or publications. • Consider collecting strong indicators regularly disaggregated by age, sex, economic status and location (via census and other surveys on attitudes and behaviours in targeted districts) for effective planning, budgeting and monitoring of NSP implementation at the local level and better targeting of disadvantaged groups	*Rationale:* regular comprehensive data is required to inform to inform policy, programs, and research • Surveys tend to capture the family planning methods of married women only (overestimating CPR and underestimating unmet needs). To prevent unwanted adolescent pregnancies, consider capturing comprehensive family planning data regardless of marital status.	- A mapping of sexuality education and service data collected across surveys and related reporting timelines to inform the integration of regular data collection to feedback into the sexuality education and services planning.	- Produce and implement a mapping of sexuality education and service data referred to under expected outcomes.	LPPKN
Limited use of innovative, non-traditional and age appropriate interventions in adolescent SRH programming.	• Use innovative digital technologies to reach the young people such as the use of Information and Communication Technology (ICT), game-based or interactive interventions in SRH programming	• There is a strong reliance on traditional approaches such as peer-education or community-based awareness raising programs (important entry points for those aged 10-14).	- Increase the piloting of innovative interventions in adolescent SRH programming based on international evidence of best practices, and scale up successful innovations.	• Number of innovative initiatives piloted • Number of innovative interventions scaled-up	LPPKN and FRHAM

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
	• Consider non-traditional approaches, such as sports-based interventions, psychosocial counseling, mental health counseling. • Consider a distinct programmatic area with strong technical interface with other areas to attract and reach greater numbers of young people, with SRH and gender equality information and services. • Consider promoting the website the Malaysian Care for Adolescent Project (MyCAP), created by health professionals for online sexuality education among Malaysian young people.	• Innovative approaches and technologies are underutilised			
Lack of an overall robust monitoring and evaluation (M&E) mechanism • Limited rigorous evaluation and documentation of what works. • Most programmes did not conduct rigorous impact evaluations necessary to inform evidence based SRH programming.	**Establish a robust M&E mechanism to measure progress validate, replicate or scale up best practices in Malaysia** • Implement more methodologically rigorous quantitative and qualitative evaluation studies adopting both quantitative and qualitative methodologies using longitudinal designs are required to inform the factors contributing to program effectiveness • Mainstream gender in all outcome areas within programmes for gender equity and women's empowerment • Consider a population related observatory to M&E Strategies' implementation that collects and harmonises available data and indicators; and assess/bridge data	*Rationale:* a strong M&E framework can identify interventions that improve adolescent's SRH knowledge, access and uptake of services as well as gaps in programing knowledge and practice to build an evidence-based scale up of promising interventions, limit ineffective or duplicate efforts and ensure efficiency of available resources.	1. A stronger CSE M&E mechanism 2. A team overseeing indicators at national, state and district level 3. Team at national state and district levels	- **MOE:** Number of trainings (per year) completed at National, State and District level. - Number of young people's participating at each monitoring level. **Schools/teachers:** - Number of teaching hours and topics completed - Number of students reached	MoH, LPPKN and FRHAM

Gaps and Barriers	Recommendations	Rationale	Expected outcomes	Indicators	Propose lead agency
	gaps with new surveys or innovative research methods such as crowdsourcing and big data methodologies. • Establish databases containing effective programs and measures for more effective dissemination of informed practice • Monitor program implementation and service provision for young people by key agencies, focusing on progress made and identification of facilitating factors, gaps and constraints, as well as emerging issues that require attention to strengthen the current programs and services. • Conduct regular client's exit interviews and assessments on the capacity of service providers to assess the effectiveness and efficacy of the programs and services. Integrate the M&E framework across key agencies for more reliable and useful information.				

Appendix 6: Draft 2020-24 PEKERTI Plan of Action

CORE ASPECTS	OBJECTIVE	STRATEGY	PROGRAMMES FOR YEARS (2020-24)				
			2020	2021	2022	2023	2024
ADVOCACY AND PROMOTION	1. To increase public awareness on the importance of reproductive health education and Family Planning practice	1. Reduce sensitivity and misrepresentation of SRHE (Reproductive and Social Health Education) through the provision of dedicated support programmes to parents, family members, guardians, teachers, health personnel, caregivers and communities.	Road map to disseminate information and encourage public participation in SRHE through education, promotion and publicity programmes.				
			Programme to improve SRHE curriculum and advocacy from pre-school through to tertiary levels in partnership with the Education Ministries. Link SHRE education to referrals for services for the older age groups (secondary & tertiary education)				
			Programme to improve out-of-school interventions Link SHRE education to referrals for services for the older age groups				
			Programme to prepare and improve parental skill programmes				
			Programme to improve pre-marital courses.				
			Programme to improve health personnel attitudes, beliefs and behaviours and eliminate stigma when delivering SHR education and services. Link SHRE education to referrals for services				
		2. Establishing and enhancing strategic multi-sectoral collaboration. to develop/improve preventive programmes and interventions (program 6 + 7)	Increase strategic multi-sectoral partnership among key stakeholders and relevant agencies, and promote a multi-disciplinary approach to deliver sexuality education and services				
		3. To strengthen promotion and publicity of PEKERTI	Develop and implement behavioural change management plan to raise community awareness on SRHE and promote public engagement and participation using different mass media channels (TV, radio, newspaper, community events, mark international days related to SRHE)				
	2. To strengthen preventive measures through reproductive and social health education	4. To strengthen preventive measures through reproductive and social health education.	Programme to foster and nurture SRHE know-how to create socially responsible and positive individuals in relation to reproductive and social health (SRHE)				
HUMAN CAPITAL DEVELOPMENT	3. To develop the expertise of reproductive and social health education among communities	5. Develop human capital trained in the field of SRHE - Capacity building for teachers - Capacity building within society - Training Programme on SRHE expertise to community support groups for cases of abuse, neglect and exploitation	Identify and train champions for SRHE		Engage champions in disseminating research findings to the community		
			Improve Capacity Building for teachers from pre-school to tertiary levels (skills and expertise via Reproductive Health Module) incorporating gender equality		Implement training modules for teachers and conduct programme baseline, midline and endline surveys to assess changes in attitudes, beliefs and behaviours regarding SRHE		
			Develop training accreditation programme for teachers		Implement accreditation program		
			Improve Coaching Programme of trained trainers (Master Trainer)		Assess programme success at baseline, midline and endline via behavioural surveys		
			Institutionalise sexuality education as a compulsory subject in schools as a long-term goal.				
			Develop training modules for parents		Implement training modules for parents and conduct programme		

CORE ASPECTS	OBJECTIVE	STRATEGY	PROGRAMMES FOR YEARS (2020-24)				
			2020	2021	2022	2023	2024
					baseline, midline and end line surveys to assess changes in attitudes, beliefs and behaviours regarding SRHE		
			Develop training modules for religious leaders		Implement training modules for religious leaders and conduct programme baseline, midline and end line surveys to assess changes in attitudes, beliefs and behaviours regarding SRHE		
			Deliver key SHRE messages to Children/Youth, the unmarried, the married		Conduct programme baseline, midline and end line surveys to assess changes in attitudes, beliefs and behaviours regarding SRHE. Identify successful programs for scale up.		
			Capacity Building across different groups				
RESEARCH AND DEVELOPMENT	4. To enhance research and development towards a better reproductive and social health education system	6. To perform and improve research and development of SRHE	Provide a comprehensive road map or SRHE research				
				Provide funding for SRHE research			
				Enhance collaboration between national and international agengies (aling national reporting to international standards)			
				Enhance national, logitudinal and implementation research in SRHE (identify succesful programmes and componets for scale up)			
				Increase effectiveness of reviews of SHRE modules and programmes			
			17. Collection of research learnings and outcomes				
			18. Benchmarking				
		7. Enhance accessibility to all relevant resources in the field of SRHE	Establish a Technical Committee to coordinate and develop a comprehensive SRHE database				
				Establish a SRH National Database for Monitoring and Evaluation of the programmes			
		8. Expanding the field of youth reproductive health research	21. Identify, collect and disseminate youth reproductive health research				
MONITORING & EVALUATION	5. The implementation of reproductive and social health education	9. Coordination, monitoring and evaluation for SRHE programme implementation	22. Establish a Technical Committee to coordinate, monitor and evaluate the effectiveness of SRHE (this Committee can be the same as the research one)				
				Assessment of the modules/programmes conducted			
							Review SRHE PoA

Monitoring and Evaluation Framework and indicators

Core aspect 1. Advocacy, promotion and awareness raising programmes:

1. Increase public awareness of RHE and family planning practice by 20-24 via: a) a road map to disseminate information and encourage public participation; b) targeted support programs to students, parents, teachers, religious leaders, health personnel & family (parental training and pre-marital courses); b) multisectoral collaboration; c) promote PEKERTI via media plan

2. Strengthen preventive measures via reproductive & social health education (RSHE) at all levels of schooling and out-of-school

Activities	Implementing Agencies	Indicators	Measure of success
1) To disseminate information and to encourage participation in SHRE through education, promotion dan publicity programmes (Programme 5).	*KPWKM/LPPKN*, *JAKIM*, MOH, MOE, MOHE, MOH, MINISTY OF HOUSING AND LOCAL GOVERNMENT (*KPKT*), Youth and Sports Ministry (*KBS*), Local Councils (*PBT*)	No. of SHRE Skills Development & Education Programmes No. of Participants of SHRE Skills Development Programmes No. of Reference/SHRE Services Centres (including online) No. of print, electronic and social media promotional content	1) The percentage increase of SHRE of knowledge and awareness across all age groups over a period of 5 years. 2) The percentage increase of positive attitude about SHRE over a period of 5 years. 3) Increase in the no. of participation in SHRE educational & skills development programmes. 4) The percentage of satisfaction level for SHRE-related services. 5) Reduction in teen pregnancies (unmarried). 6) Reduction in baby dumping. 7) Reduction in sexual diseases (STI/HIV). 8) Reduction in Gender-Based Violence (GBV)
2) To improve SHRE curriculum from pre-school to tertiary levels.	Youth and Sports Ministry (*KBS*)	No. of sessions/duration of teaching Percentage of SHRE component in the curriculum No. of age groups with access to SHRE	
3) To prepare and improve parenting skills programmes.	KPWKM/LPPKN, JAKIM, MOH (*KKM*), MOHE (*KPT*), MOE (*KPM*), Local Councils (*PBT*), MINISTRY OF HOUSING AND LOCAL GOVERNMENT (*KPKT*), *JABATAN PERPADUAN NEGARA DAN INTEGRASI NASIONAL (JPNIN),* NGO	No. of parenting programmes Percentage of SHRE component in parenting skills module	
4) To improve pre-marital courses.	*JAKIM, JAIN* (State level Islamic Body), *LPPKN*	No. of sessions/duration of teaching Percentage of SHRE component in pre-marital module	
5) To develop and improve preventive programmes and interventions. (program 6 + program 7)	*KPWKM/LPPKN, JAKIM,* MOH (*KKM*), MOHE (*KPT*), MOE (*KPM*), Youth and Sports Ministry (*KBS*), MINISTRY OF HOUSING AND LOCAL GOVERNMENT (*KPKT*), *JPNIN*, NGO	No. of Preventive Programs No. of Interventions (e.g. *Generasiku Sayang*) Prevention Programmes (e.g. "Say No to "*Zina*" (Adultery) campaign, Campaign to Promote the Use of Condoms)	
6) To increase strategic collaborations between relevant agencies.	*KPWKM/LPPKN, JAKIM*, MOH (*KKM*), MOHE (*KPT*), MOE (*KPM*), Youth and Sports Ministry (*KBS*), MINISTRY OF HOUSING AND LOCAL GOVERNMENT (*KPKT*), *JPNIN*, NGO	No. of Inter-agency Collaboration	

Core aspect 2 : Human Capital Development

Develop expertise of RSHE among communities by (20-21): 1) a trained trainer's program; 2) RSHE training programme to support abuse, neglect and exploitation; 3) RH Module; 4) capacity building (20-24)

Activities	Implementing Agencies	Indicators	Measure of success
1) Identify SRHE 'champions' 2) Identify the platform for champions (media: forum, Radio Ikim, SPM, etc.) 3) Involve champions in any Technical Working Committee (TWC) (e.g. ACCRH) 4) MOE: Identify the 'SRH best practices' (schools) and conduct regular competitions/conventions on SRH Best Practices for sustainability	Academic experts, politicians, professionals and celebrities etc	At least 2 people/state No. of Platforms No. of champions in TWC No. of Best Practices schools No. of competitions/ conventions held	Sustained Increase of Champions/State Increased Community awareness of SRH from baseline (Malaysian Population Family Survey, *IKK*)
1) Improve Capacity Building module including gender equality (+softcopy/PPT/video/IEC materials) - All ages - Online Learning Portal - Pre/Post evaluation *Institutionalizing sexuality education as a compulsory subject in schools as a long-term goal. - Creating enabling tools and environment for capacity building on SRH	MWFCD (*KPWKM*)/ NPFDB(*LPPKN*)/MOH (*KKM*)/MOE (*KPM*)/Youth and Sports Ministry (*KBS*)/ MOHE (*KPT*)/*JAKIM*/ *PERPADUAN* Ministry	No. of Workshops to develop Module/IEC materials/year	RH Module for Children RH Module for Youth RH Module for Adults RH Modules for senior citizens RH module for vulnerable/high risk groups
1) Develop an accreditation programme for Capacity Building - e.g. collaborate with MOHE/*INTAN/ISM* etc. to develop the SRH Awareness Module Accreditation Program Online/Offline	MWFCD (*KPWKM*)/ NPFDB(*LPPKN*)/MOH (*KKM*)/MOE (*KPM*)/Youth and Sports Ministry (*KBS*)/MOHE (*KPT*)/*JAKIM/ PERPADUAN* Ministry/Human Resources Ministry/*ISM/INTAN*	No. of Workshops/Meetings for the development of the SRH accreditation module No. of participants for accreditation	Accreditation module Certificate of SRH Accreditation
1) Increase Coaching Programmes (Master trainers) - National - State - District - Community - Trainee teacher (IPGM), MOE (*KPM*) establishes CPD points {to be explored}: implementing SRH teachers- Counseling, Biology, PK, Moral/Religious studies * Identify funding source to support human capital development activities/programmes (3P sharing cost) 2) Establish Trainers database	MWFCD(*KPWKM*)/ NPFDB(*LPPKN*)/MOH (*KKM*)/MOF/MOHE (*KPM*)/ Youth and Sports Ministry (*KBS*)/Rural Development Ministry (*KPLB*)/MOHE (*KPT*)/ *PERPADUAN* Ministry/Welfare Department (*JKM*)/*ISM*/NGO/Parent-Teacher Association (PTA), *Persatuan Wanita*/PRIVATE (DUREX & etc) Department of Occupational Safety (DOSH)/*JAKIM*/INTERFAITH Groups/MEDIA Relevant implementing agencies	No. of Master trainers/TOT/year No. TOT Programmes Trainers and master trainers database Funds allocated for SRH programmes/activities	Increase of Master trainers/Trainers
1) Capacity building within society - Children/Youth at college/university - *Rakan Muda*/Youth leaders/*Rukun Tetangga*/Teen Peer Educators	MWFCD (*KPWKM*)/ NPFDB (*LPPKN*)/MOH (*KKM*)/MOHE (*KPM*)/ Ministry of Housing and Local Government (*KPKT*)/Youth	No. of trained Participants per setting/ Agency No. of Programmes per Setting/agency	Increase in trained participants and the knowledge of SRH

Activities	Implementing Agencies	Indicators	Measure of success
(*Pandu Puteri, KafeTEEN* teen educator, primary and high school doctor *muda*, *PROSTAR, PROSIS* etc) - Short stories, poetry, video competitions etc related to SRH - Strengthen the promotion of SRH facilities - Religious/ Cultural dialogue - Media - RH course by *INTAN* *Institutionalizing sexuality education as a compulsory subject in schools as a long-term goal. (INVESTING IN OUR FUTURE Policy & Planning Brief: A framework for accelerating action for the SRH of young people by WHO/UNFPA/UNICEF)	and Sports Ministry (*KBS*)/Rural Development Ministry (*KPLB*)/MOHE (*KPT*)/PERPADUAN Ministry/Welfare Department (*JKM*)/*ISM*/NGO/ PRIVATE (DUREX & etc) Department of Occupational Safety (DOSH)/ *JAKIM*/INTERFAITH Groups/MEDIA	No. of Competitions conducted No. of Participants No. of Forums/training involving religious bodies No. of Forums/training involving media No. of courses implemented by INTAN	

Core aspect 3: Research & Development

Enhance R&D towards a better RSHE by: 1) improving data collection on outcomes for benchmarking; 2) enhancing accessibility to relevant RSHE resources via a systematic database and a task force to develop it; 3) expanding youth reproductive health research by identifying, collecting and disseminating it (20-24).

Activities	Implementing Agencies	Indicators	Measure of success
To perform and improve SRHE research and development <u>Short term (2020)</u> 1) Provide a comprehensive roadmap in the field of SRH <u>Long term (2020-2025)</u> 1) Provide funding for research in the field of SRH 2) To enhance collaboration between national and international agencies 3) To enhance longitudinal, national and Action Research in SRH field 4) To increase assessment/effectiveness reviews of SRH modules and programs	MOF MWFCD *(KPWKM)* /NPFDB (*LPPKN*) MOH (*KKM*) Youth and Sports Ministry (*KBS*) MOHE (*KPT*) MOE (*KPM*) Ministry of Housing and Local Government (*KPKT*) *JAKIM* NGO	1) Comprehensive Research Roadmap 2) Funds allocation for SRHE beginning year 2022 3) Number of research collaborations (including technical support) 4) Number of studies 5) Number of assessment/effectiveness reviews of SRH modules and programs	1) Improve data availability and SRH-related analysis Baseline: Roadmap (2020), existing data limitations and unavailability of related data 2) Development and implementation of effective programmes/modules Baseline: Data of the number of programmes and evaluated SRH modules from agencies and NGOs in 2022.
Enhance accessibility to all relevant resources in the field of SRHE <u>Short term (2020)</u> 1) Establish the National Committee for SRH Data <u>Long term (2020-2025)</u> 1) Develop SRH National Database	MWFCD *(KPWKM)* /NPFDB (*LPPKN*) MOH (*KKM*) Youth and Sports Ministry (*KBS*) MOHE (*KPT*) MOE (*KPM*) Ministry of Housing and Local Government (*KPKT*) *JAKIM* NGO	1) A Technical Working Committee 2) A system	Improve data availability and SRH-related analysis

Core aspect 4: Monitoring and Evaluation

Implementation of RSHE, M&E by establishing a technical committee of RSHE experts led by a Steering committee

Activities	Implementing Agencies	Indicators	Measure of success
By 2020: The establishment of one (1) Committee to coordinate, monitor and evaluate the effectiveness of SRHE implementation	MWFCD (KPWKM) MOH (KKM) MOE (KPM) Ministry of Home Affairs (KDN/PDRM) MOHE (KPT) Youth and Sports Ministry (KBS) MCMC NPFDB (LPPKN) JAKIM JPNIN Welfare Ministry (JKM) NGO Parent-Teacher Association (PIBG)	One National Monitoring and Evaluation Committee established	75% of the effective SRHE Programmes Note: 2020-2024 Number of all evaluated existing SRHE Programs
During 2020-2024: Assessment of the modules/programmes conducted		Number of monitoring and evaluation reports of programmes/ modules Number of guidelines	
Review of effectiveness of PEKERTI PoA			