COMPREHENSIVE SEXUALITY EDUCATION PROGRAM FOR ADOLESCENTS IN THE REPUBLIC OF TAJIKISTAN

ACHIEVEMENTS, CHALLENGES, OPPORTUNITIES

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"Comprehensive Sexuality Education Program for Adolescents in The Republic of Tajikistan. Achievements, Challenges, Opportunities".

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Science in Public Health

by

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Declaration:
Where other people's work has been used (from either a printed source, the internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "Comprehensive Sexuality Education Program for Adolescents in The Republic of Tajikistan. Achievements, Challenges, Opportunities" is my own work.

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASRHR	Adolescents sexual and reproductive health and rights
BZgA	The Federal Centre for Health Education (Germany)
CSE	Comprehensive sexuality education
DOI	Diffusion of Innovation Theory
EECA	Eastern Europe and Central Asia
GIZ	German International Development Agency
HIV	Human immunodeficiency virus
HLS	Healthy lifestyle
HLSE	Healthy lifestyle education
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IPPF EN	International Planned Parenthood Federation European Network
KI	Key informant
KII	Key informant interview
KIT	KIT Royal Tropical Institute
NGO	Non-governmental organisation
PLWH	People living with HIV
RH	Reproductive health
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SE	Sexuality education
STIs	Sexually transmitted infections
SDGs	Sustainable Developments Goals
TFPA	Tajik Family Planning Association
WHO	The World Health Organization
WHO Euro	WHO Regional Office for Europe
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNESCO IITE	UNESCO Institute for the Information Technologies in Education
UNFPA	United Nations Population Fund
YFHS	Youth-friendly health services

Glossary

Age Appropriate: suitable for a particular age or age group

Age definition: children: 0-18 years; adolescents: 10-19 years; youth: 15-24 years; young people 10-24 years

Demographic window: period of time in a nation's demographic evolution when the proportion of population of working age group is particularly prominent. This occurs when the demographic architecture of a population becomes younger and the percentage of people able to work reaches its height

Essential package of sexual and reproductive health services: commonly recognized components of sexual and reproductive health, including contraceptive services, maternal and newborn care, and prevention and treatment of HIV/AIDS. It also includes less commonly provided interventions that are necessary for a holistic approach to addressing SRHR: care for sexually transmitted infections (STIs) other than HIV; comprehensive sexuality education; safe abortion care; prevention, detection and counselling for gender-based violence; prevention, detection and treatment of infertility and cervical cancer; and counselling and care for sexual health and well-being.

Fiscal space: the budgetary room that allows a government to provide resources for public purposes without undermining fiscal sustainability. According to the International Monetary Fund, fiscal space exists if a government can raise spending or lower taxes without endangering market access and putting debt sustainability at risk (source: World Health Organization)

Healthy lifestyle education: A strategy to prevent risky behaviour, major health and social problems; and to prepare young people for their roles as healthy, productive adults.

Holistic: considering a whole thing or being more than a collection of parts (*Oxford Dictionary*)

Sexuality: 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 (source: World Health Organization)

Sexual risk behaviour: early initiation of sex, multiple sex partners, unprotected sex, low condom and contraception use

Abstract

Background

Age-appropriate sexuality education (SE) targeted to the young generation is a cost-effective public health intervention. In Tajikistan, adolescents sexual and reproductive health (ASRH) has several critical points: rising rates of HIV and sexually transmitted diseases, a high number of early marriages and pregnancies, and low health literacy. Still little is known about the system response and how SE program accommodates these ASRH needs.

This study sought to analyse current developments of the SE program in Tajikistan, its legal framework, policies, comprehensiveness of curricula, enablers and barriers, including alignment with principles of an effective, comprehensive SE program.

Methods

A literature review was conducted, along with five semi-structured key informant interviews and assessment of national policies and laws. The data were analysed using a model of elements of an effective CSE program: enabling environment, curriculum content, teacher training, contextualised delivery and support of youth-friendly health services (YFHS).

Results and conclusions

Results reveal progress at the policy level, improvements of curriculum content, introduction of SE in pilots, initiatives outside the school setting and the link to YFHS. The effectiveness of SE is challenged by a lack of comprehensiveness, the non-compulsory status of SE, cultural resistance, and a high dependency on external assistance.

To improve the situation, it is recommended to intensify advocacy towards compulsory status and a comprehensive approach to SE, enhance regional knowledge exchange, make use of the innovative technologies in education and integrated delivery, establish monitoring and evaluation systems, conduct a fiscal space analysis for program scale-up and sustainability.

Key words: comprehensive sexuality education (CSE), sexual and reproductive health and rights (SRHR), adolescents, implementation, Tajikistan

Word Count: 12370

Introduction

Before I joined the master's in public health program at KIT Royal Tropical Institute in Amsterdam, I used to work for a Dutch NGO in The Hague, involved in the implementation of health-related projects in low- and middle-income countries (LMIC), including Central Asian countries. Inspired and motivated by my previous work achievements I have chosen for further professional growth and development and focused my professional interest on sexual and reproductive health and rights (SRHR) in Eastern Europe and Central Asia (EECA).

When I was looking for my thesis topic, I decided to contact Dutch professionals engaged in SRHR work in that region first and requested their advice regarding current challenges in this field. The need for sexuality education (SE) came out as one of the priorities for the region. From my own experience, I knew that SE was always a difficult topic of discussion in most of the post-Soviet countries, where societal resistance is still a persistent problem. I decided to follow that advice and dove into the specifics of this theme in The Republic of Tajikistan.

SE in the WHO European Region has a long history. It started with Sweden, where this subject was already included in the school curriculum in 1955. Most West European countries followed that example and introduced the program between 1960-1970. Some of the Eastern European and most of the Central Asian countries are at the beginning of this process, and there are differences in level of progress in SE implementation throughout the region.

Given specific historical, political and cultural aspects of Tajikistan, there is still little known about the current status and developments in the area of the SE program, its legal framework, existing policies, comprehensiveness of curricula, enablers and barriers. Tajikistan is an LMIC country in the WHO European Region with a significant youth population (Tajikistan Country Profile, see Table 1). Investing in their health and well-being is a critical aspect of many national strategies. International development organisations and donors support the Tajik government in this priority area by providing technical and financial assistance.

Sexuality as a thesis topic allowed me to investigate a broad scale of SRHR related areas in the country: from epidemiology and demography, through to the social determinants of health and up to levels of policy and governance. This study brought me in close contact with agencies operating in the country in this field, and as a result, my understanding of regional, as well as country-specific challenges and opportunities for SE increased significantly. Once my thesis is finished, I plan to distribute my findings and recommendations to the agencies involved in this work in Tajikistan and hope to contribute to the further development of SE in the EECA region.

Table 1. Country Profile Tajikistan

Tajikistan Country Profile

Geographical Location:
Central Asia, west of China, south of Kyrgyzstan
Distance from The Netherlands: 5154 km
Capital City:
Dushanbe (916,000 population) (2020) (3)
Land Area: 142,600 square kilometres (1)
Terrain:
93% of the country is covered by the massive mountain systems of Central Asia (3)

People	
Population	9,127,000 (01/01/2019) (1)
Religion	Muslim 98% (Sunni 95%, Shia 3%) other 2% (2014 est.) (3)
Language	Tajik (official) 84.4%, Uzbek 11.9%, Kyrgyz 8%, Russian 5%, other 2.4% (2010 est.) (3) Note: Russian widely used in government and business
Urban population	26.3% (2019) (1)
Population growth rate (average annual %)	2.2%-2.5% (2010-2018) (2)
Age structure	0-14 years: 31.43%; 15-24 years: 18.13%; 25-54 years: 40.58%; 55-64 years: 6.23%; 65 years and over: 3.63% (3)
Life expectancy at birth, total (years)	71 (2018) (2)
Fertility rate, total (birth per women)	3.6 (2)
Socio-Economic Indicators	
Poverty rate	27.4% (2018) (2)
Gross Domestic Product per capita (US$)	801 (2017) (5)
Current Health Expenditure per capita (US$)	58 (2017) (5)
Net official development assistance received (current US$) (millions)	397.5 (2018) (2)

(1) National Statistics Agency https://www.stat.tj/
(2) World Bank https://databank.worldbank.org/
(3) CIA World Factbook, last update June 11, 2020 https://www.cia.gov/library/publications/the-world-factbook/geos/ti.html
(4) Demographic Health Survey 2017
(5) WHO https://apps.who.int/nha/database/country_profile/Index/en

1 BACKGROUND

This chapter provides information about the rationale behind the SE and comprehensive sexuality education (CSE) program, its development in Europe, as well as the problem statement, justification and objectives of this thesis.

1.1 Comprehensive Sexuality Education. What is this and why it is important?

"Sexuality education delivered within a safe and enabling learning environment and alongside access to health services has a positive and life-long effect on the health and well-being of young people." (1, p.1).

Good SE targeted at young people is recognised as a crucial and cost-effective public health strategy. It is an essential component of the quality education contributing to the healthy the entire population (2), (3). The rationale behind the provision of SE in or out of school goes beyond purely sexual and reproductive health (SRH) related questions. It stresses a human rights-based approach to health for all and empowers young people, especially girls, to make informed decisions related to their sexual life. It addresses existing gender equalities and equips young people with accurate knowledge related to their health (1). Initiated in 1994 at the International Conference on Population and Development (ICPD), this approach supports the vision of SRH and the needs of each individual, rather than focussing on population control (4).

In recent years, the global health community has devoted more attention to adolescent sexual and reproductive health and rights (ASRHR) (5), (6). Professionals emphasise that adolescents are the key population for nearly all SRH services (7), (8), but more needs to be done in terms of recognising their needs, build an enabling environment, targeted programming, scaling up access to services and intervention financing for this often-neglected group. The World Health Organization (WHO) identifies the provision of the accurate, age-appropriate CSE as a critical part of all SRH interventions and includes this component in the essential package of SRH services to be provided (9).

The development and implementation of national CSE programs involves different stakeholders and is often the shared responsibility of both the Ministry of Education and the Ministry of Health. It might also include support from other (international) development organisations and NGOs working in this area, especially in low- and middle-income countries.

To support countries, in 2018, the United Nations Educational, Scientific and Cultural Organization (UNESCO) published a revised edition of the International Technical Guidance on Sexuality Education (10). This issue is based on the new evidence and is aligned with the Sustainable Developments Goals (SDGs) Agenda 2030. It emphasises a rights-based approach to SE, promotes gender equality, well-being and a recipient-centred positive approach to sexuality.

In this paper, the UNESCO definition of CSE education is being used:

"Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives" (10, p.16).

SE in the WHO European Region has a long history. It started with Sweden, where this subject was already included in the school curriculum in 1955. Most West European countries followed that example and introduced the program between 1960-1970 (11). SE has accelerated dramatically in the past few years due to global attention on adolescent SRH (7), (12), (13).

In 2010, the WHO Regional Office for Europe (WHO Euro) in collaboration with The Federal Centre for Health Education (BZgA) introduced the Standards for the Sexuality Education in Europe (The Standards) (14). This document was a reaction to requests from the countries for assistance in developing SE programs. The document provides policymakers, and educational and health authorities with the general framework of topics for CSE, which can be used either for the development or the updating of curricula.

In 2013, WHO Euro & BZgA produced the Guidance for Implementation of the earlier published Standards (15). It provides assistance on how a school-based program can be designed and which requirements should be met. Given the existing differences in approaches to SE across Europe, these recommendations can be adjusted to the country context.

In this paper, CSE was approached from a broader angle of an *effective comprehensive sexuality education program*. It includes four other components: an enabling environment, appropriate training for educators, contextualised delivery, and availability of YFHS.

The term *comprehensive* refers to the fact-based curriculum content, which should reflect a full set of age-appropriate thematic components, which are aligned with The Standards and are supported by a holistic approach to SRH. The cultural climate and national priorities for health and education can influence the elements of an SE program, including the comprehensiveness of the content. A selective approach to aspects of the SE program, can jeopardise its effectiveness and create knowledge or service gaps, which can elevate the risks of poor health outcomes.

Given the specific historical, political and cultural aspects of Tajikistan, there is still little known about the current status and developments in the area of SE programming in this particular country, its legal framework, existing policies, the comprehensiveness of curricula, the enablers and barriers (11).

1.2 Problem Statement and Justification

The sexual and reproductive health of adolescents in Tajikistan is affected by several key factors: Human Immunodeficiency virus (HIV) infection is rising among the general population. Between 2010 and 2019, new HIV infections increased by 23%, and is increasingly affecting more women than men (16). The primary factor contributing to this trend is a change in the main pathway of the transmission, which has shifted from injecting drugs to sexual transmission (17). This change leads to an increased vulnerability of sexually active adolescents to HIV infection. Children aged between 0-18 make up 10% of the total number of people living with HIV (PLWH), where young people aged 19-26 years contribute already 28.4% of the total number of PLWH (18). In this context, awareness and knowledge about HIV transmission are crucial to avoid transmission, but these continue to be low (19). Among older adolescent girls between 15-19-years-old, only 33% have ever heard about HIV, only 21% possess comprehensive knowledge about HIV transmission, 9% know where and how to access the HIV testing facility, and only 3% were ever tested for HIV and got results.

A gender assessment report stresses that many adolescents and young people in Tajikistan do not possess basic general knowledge on reproductive health and hygiene: 46% of male

and 51% of female adolescents do not use condoms, 7% of the respondents (mainly under 20-years-old) are not familiar with the term *contraception* (20).

The increased prevalence of gonorrhoea and syphilis, among young people aged 19-26 (62% of the total number registered cases among all ages), proves the risks and vulnerability of adolescents to STIs as well (21). Other indicators, such as an increased proportion of sexually active adolescents, early marriage (13% of 15-19-year-old girls are married), high adolescent pregnancy rates (8% among 18-year-olds, 26% among 19-year-old girls), low contraception use among adolescent girls (2-3%) and increasing violence against young girls (19), should urge health authorities to rethink their approach to adolescent health. Selected SRH indicators are summarised in Table 2.

The demographic data of Tajikistan supports this need: the younger generation aged 0-24 years of age make up 52% of country's population, where 34% of this group are adolescents, aged 10-19 (22). The WHO defines adolescence as a distinct period in life when the process of transition from childhood to adulthood takes place with significant implications for the existing and future health status of the individuals, and therefore, requires explicit attention in national health policies (23).

Table 2. Tajikistan SRH statistics for adolescents

Indicator	Value	Year	Data source
Percentage of married or currently in union female adolescents aged 15-19	12.60%	2017	DHS
Percentage of women age 25-49 who had married at age 18	13%	2017	DHS
Median age at first sexual intercourse (among women aged 25-49 years)	20.2	2017	DHS
Median age at first birth	21.9	2017	DHS
Adolescent pregnancy (among women aged 15-18 year)	8%	2017	DHS
Adolescent pregnancy (among women aged 19 years)	26%	2017	DHS
Contraception prevalence rate (among married women aged 15-19 years)	3%	2017	DHS
Contraception prevalence rate (among all women 15-49)	21%	2017	DHS
Perinatal mortality rate younger than 20 years (the sum of the number of stillbirths and early neonatal deaths divided by the number of pregnancies of 7 or more months' duration)	30/1000	2017	DHS
Percentage of women with comprehensive knowledge about HIV, which includes answers at least with two measure, such as condom use, and sexual contact limited to one partner (among girls aged 15-17 years)	5%	2017	DHS
Percentage of women with comprehensive knowledge about HIV, which includes answers at least with two measure, such as condom use, and sexual contact limited to one partner (among women aged 18-24 years)	14%-17%	2017	DHS
Percentage of women aged 15-19 years who have heard about HIV or AIDS	33%	2017	DHS
Percentage of women aged 15-19 who know where to get an HIV test	9%	2017	DHS
Percentage of women aged 15-19 who were ever tested and got results	3%	2017	DHS
Total Number of HIV new cases in 2019 (all ages)	1320	2020	National HIV Center
Percentage of HIV new cases due to sexual transmission in 2019 (all ages)	70%	2020	National HIV Center
Proportion of men/women among HIV new cases in 2019 (all ages)	58%/42%	2020	National HIV Center
Achievement UNAID 90-90-90 targets	63-81-74	2020	National HIV Center

According to a survey conducted in Tajikistan (2014) among a group of young people between 15-29 years of age, speaking about sexuality and sexual behaviour is still considered a taboo. Adolescents and young people are hesitant in seeking advice on reproductive health questions in regular facilities. An feeing of awkwardness when talking about this topic with an adult, a perceived lack confidentiality, a preference to discuss these sensitive questions with a young health professional of the same sex, are all factors keeping young people away from health facilities (24).

These numbers, in combination with a high incidence of domestic and gender-based violence, adolescent pregnancies, the growing HIV epidemic and the prevalence of sexually transmitted diseases affecting young people, emphasise the need for a strategic and integrated approach for the improvement of health outcomes needed to achieve the goals in 2030 Agenda for Sustainable Development. Age-appropriate CSE is one of the tools which can address poor sexual health and gender inequalities and increase the health literacy of new generation in a sustainable way.

Until now, little was known about the comprehensiveness of the curriculum of SE in Tajikistan. How regional standards and recommendations on CSE have been reflected in the teaching materials? How regional standards and recommendations on CSE have been reflected in the teaching materials? Who is responsible for the development, implementation and financing? This thesis will endeavour to fill this gap by focusing on these areas, summarising practices, and identifying successes, achievements and opportunities.

This study focuses on adolescents (aged 10-19). Adolescence is an important transitional stage of physical and psychological development of individuals. As mentioned previously, Tajikistan is a young nation with a median age of 22.4 years (25). It is crucial to understand the needs and factors influencing their health and well-being and to improve health system responses accordingly. Understanding and addressing these determinants will accelerate the implementation and further adoption of CSE.

1.3 Objectives

The main objective was to assess current developments in the SE program for adolescents in Tajikistan. What determines its comprehensiveness, effectiveness, and how the program is aligned with the principles of an effective CSE program.

The specific objectives were:

1. To explore how current strategies for SE in Tajikistan are aligned with the internationally recommended components of an effective CSE program;
2. To assess the comprehensiveness of the content of SE;
3. To explore enablers and barriers in the implementation of a CSE program in Tajikistan and the role of international organisations and NGOs in the introduction and development of a CSE program in Tajikistan;
4. To make recommendations on how the CSE program in Tajikistan can be enhanced to make it more efficient.

2 METHODOLOGY

2.1 Research Instruments

This research is based on data obtained through primary and secondary sources. A combination of methods and analysing technics were used to be able to meet the specific objectives of this study.

2.1.1 Literature review

A literature review was conducted to identify which information and data, related to the CSE and its development in Tajikistan already exist, and which can be used as the starting point for this thesis. Secondary quantitative and qualitative data from different national datasets, which are publicly available through the Governmental agencies of the Republic of Tajikistan and international development organisations were analysed.

2.1.2 Policy Analysis

In addition, a desk review of the national policies and strategies, which enable the adaptation of SE in Tajikistan was conducted, including a review of the available teaching literature used in school-based education.

2.1.3 Interviews with key informants (KIs)

To support and enrich the findings from the literature and policy reviews, interviews with key informants were organised. The clearance letter from the KIT Research Ethics Committee with the reference number S-117 for conducting the interviews was obtained on April 14th, 2020 (Annex 1).

KIs are individuals with well-informed perspectives and expertise in the field of SE in Tajikistan. They were selected based on a stakeholder analysis of organisations involved in policy development, advocacy, and the implementation of activities in Tajikistan. The purpose of the interviews was to collect data on the role of their organisations, achievements, challenges and perspectives of the CSE program in Tajikistan. The following groups of KIs were interviewed:

- Representatives of local NGOs involved in providing services and advocacy related to SE (2 persons);
- Representatives of international organisations, operating in the country and engaged in the development of national strategies and policies for CSE, such as UNFPA and the International Planned Parenthood Federation (IPPF) (3 persons).

Contact with the representative of the UNESCO Institute for the Information Technologies in Education, located in Moscow, Russian Federation (UNESCO IITE), was also established. This UNESCO agency supports Member States with the achievement of *SDG 4 Ensuring inclusive and equitable quality education for all* and *SDG 3 Ensure healthy lives and promote well-being* targets that relate to the acquisition of knowledge and skills needed for healthy and sustainable lifestyles. However, after some written communication about the role of UNESCO IITE in Tajikistan particular, referral was made to the partner in the field – UNFPA Tajikistan. Nonetheless, UNESCO IITE provided valuable information and links to sources regarding recent developments in Tajikistan. This contribution has enriched the results section of this thesis.

The semi-structured topic guide for the interviews was developed using the results from the literature and policy reviews, secondary data analysis and the assessment of components of the SE program as a basis (Annex 2).

Five KIs were interviewed via Skype video calls in May 2020. All the interviewees submitted a signed consent form prior to the interviews (Annex 3). Conversations were recorded with their permission. Interviews were conducted in Russian and then translated and transcribed into English at a later stage by the study author.

2.2 Search Strategy

The literature review was conducted in Google Scholar and the library research database from Vrije Universiteit Amsterdam with using search engines such as PubMed, ERIC and SCOPUS. The search was organised per specific objective. Keywords can be found in Table 3 below. Furthermore, the literature search in Russian was performed using Google Scholar and the same keywords as used in the English sources.

United Nations agencies, such as the World Health Organisation (WHO), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), and Tajik Government websites were also consulted for relevant and recent data, policy documents, legislation, statistics and strategies.

A snowball search method was used by consulting the relevant bibliography of key documents.

The time span for the grey literature and peer-reviewed literature was fifteen years. This is justified as global developments in this field started around this time. Inclusion criteria for policy analysis were the current active status of strategy/law or its role in the development of the successor strategy. Since Russian is widely used in the Tajik government, publications and normative documents in Russian were actively consulted.

Table 3. Keywords and combinations used for the literature search

Objectives	Keywords
General, overarching	Comprehensive Sexuality Education AND Policies OR Guidance
	Sexuality education AND Eastern Europa OR Central Asia
	Sexuality Education AND Principles OR Effectiveness
	Adolescents Sexual and Reproductive Health AND Principles
1	Sexuality Education OR Prevention education AND Tajikistan
	Healthy Lifestyle Education AND Tajikistan
	Sexual and Reproductive Health and Rights AND Tajikistan
	HIV Strategy AND Tajikistan
	Adolescents Health AND Tajikistan
	Reproductive Health AND Tajikistan AND Strategy
	YFHS OR Youth Cabinets AND Tajikistan
	Youth-friendly health services AND Tajikistan
2	Age-appropriate AND Sexuality education
	Sexuality education AND Topics OR Themes
	Sexuality education AND Delivery OR Training of trainers
3	Sexuality education AND barriers OR resistance
	Sexuality AND Tajikistan OR Central Asia

2.3 Choice of The Analytical Framework

For the analysis of data and findings from the literature and policy reviews, an analytical framework was used. To find an appropriate approach, the following steps were taken:

BOX 1. UNFPA: Nine Essential Components of Effective CSE

1) A basis in the core universal values of human rights
2) An integrated focus on gender
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 personalisation of information and strengthened skills in communication, decision-making and critical thinking
7) Strengthening youth advocacy and civic engagement
8) Cultural relevance and tackling human rights violations and gender inequality
9) Reaching across formal and informal sectors and across age groupings.

BOX 2. WHO & BZgA SE Standards. Seven Characteristics of Sexuality Education

1) Youth participation (needs-oriented approach
2) Interactive (recipient-centred)
3) Continuum of education and services
4) Multisectoral setting
5) Context-oriented
6) Cooperation with parents and community
7) Gender responsiveness.

1) Assessment of CSE guidelines of UNFPA, UNESCO, WHO, IPPF and defining of the main elements of the effective CSE program, including the visualisation of these elements;
2) Consideration of alternative methods for analyses;
3) Justification of the selected analytical framework.

2.3.1 Assessment of the International CSE Guidelines

This step was needed to understand how the effectiveness of CSE programs and the principles for successful implementation have been defined in global practice.

The UNFPA operational technical guidance on strengthening CSE programming puts a focus on a rights-based approach and gender equalities in the curriculum. The organisation defines nine essential components for effective CSE (BOX 1), and stresses the importance of multisectoral collaboration for the design and implementation of effective CSE programs (26).

The revised edition of International Technical Guidance on Sexuality Education (10), developed by UNESCO, emphasises the evidence-informed approach, where the quality of the teaching process, learning materials, and school environment have an impact on the effectiveness of the CSE program. UNESCO provides key concepts to be included in the CSE curriculum and accentuates the role of supporting elements of the CSE programs, such as well-developed national policies on CSE and SRHR, legal frameworks, effective governance and leadership, adequate financing, and links to SRH services.

The WHO Standards for Sexuality Education in Europe (14) gives guidance on the topics for school-based SE and underlines the importance of medical services providers, well-trained educators, alternatives to school-based SE, and an enabling environment (BOX 2).

IPPF, the leading NGO in the field of SRH, advocates for a right-based approach to SE, which also involves access to YFHS (2), (27).

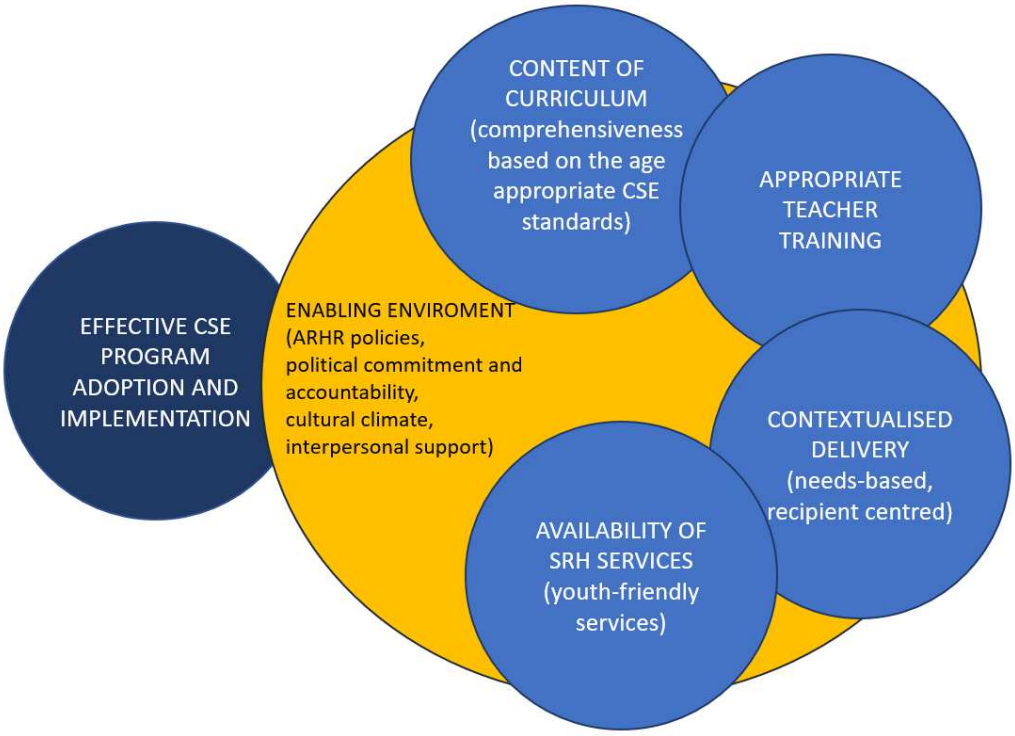
This short assessment of the technical guidelines and principles for the implementation of effective CSE programs shows that these leading organisations have a unified approach to the principles of an effective SE program. Although, understandably, the primary focus of

their interventions differs slightly from each other and is defined by the vision and mission of the specific organisation.

Based on this analysis, the critical elements of an effective CSE program were defined and visualised, as shown in Figure 1. These critical elements imply **the availability of comprehensive curriculum content, a needs-based and contextualised approach, appropriate and adequate teacher training, the availability of YFHS, as well as an enabling environment, which supports these four elements and contributes to the adoption and implementation of an effective CSE program.**

A structured assessment of each circle, as shown in Figure 1, can provide the desired answers regarding current developments in SE in Tajikistan, i.e. the comprehensiveness, enablers, barriers, and effectiveness of the CSE program.

Figure 1. Elements of an Effective CSE Program

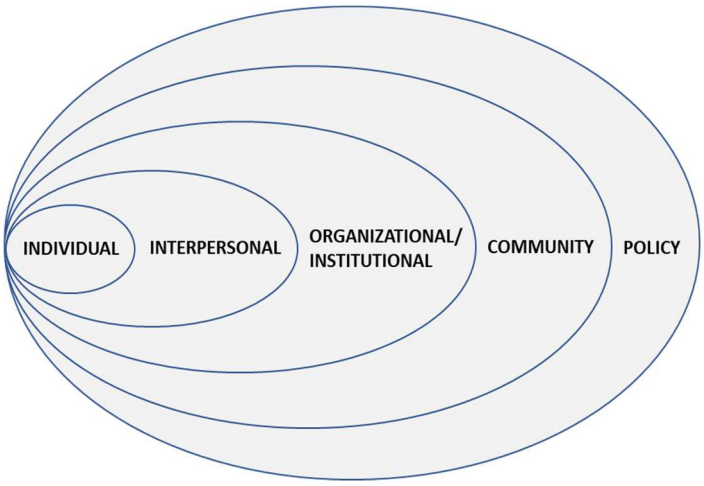


2.3.2 Alternative analytical frameworks considered

To achieve the main objective of this thesis, alternative analytical frameworks were also considered.

The first one considered was the ecological model (Figure 2). This model assumes that each of the five levels can influence the adoption, implementation and effectiveness of CSE, allowing for systematic investigation. In this case, the individual and interpersonal levels would require access to and analysis of qualitative data. This was outside the scope of this thesis and, therefore, the ecological model was no longer considered as an analytical framework.

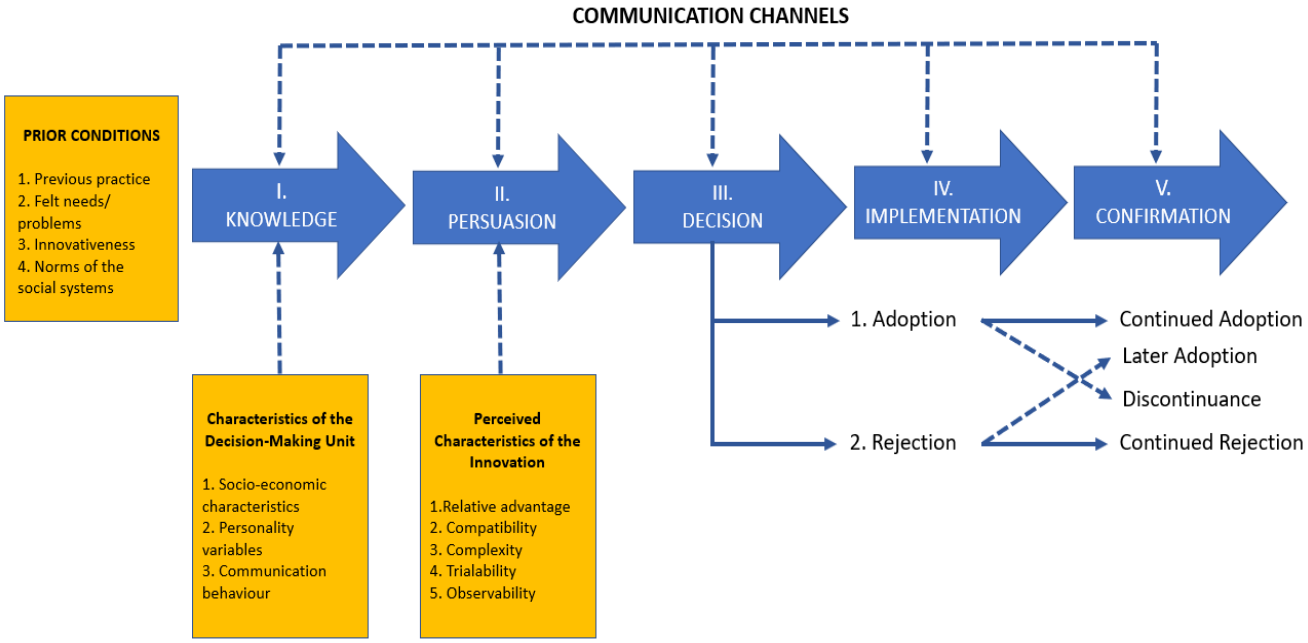
Figure 2. Ecological Model (Adapted from McLeroy, Bibeau, Steckler, & Glanz (1988))



The Diffusion of Innovation Theory *(DOI)* was another option which could help to find the desired answers for this paper. The DOI gives an understanding of how a new idea or practice which is perceived to be new (*innovation*) spreads (*diffuses*) over time through the communication channels in a given context (28).

According to Roger E.M. (28), each innovation-decision process goes through five stages: 1) *Knowledge*, 2) *Persuasion*, 3) *Decision*, 4) *Implementation*, and 5) *Confirmation*. The grade of adoption and time needed for the diffusion of the innovation depends upon the characteristics of the innovation, such as *relative advantage, compatibility, complexity, trialability, and observability*, as well as the characteristics of the decision-making units, such as *socio-economic features, personality variables, and communication behaviour (*Figure 3*).*

Figure 3. A model of the stages in the innovation-decision process (adopted from Roger.E.M. 1983)



There are examples in the literature (29), (30), where this approach is used to measure the diffusion of CSE, including the determination of the factors impacting the adoption of the innovation.

In my opinion, this approach is useful when the focus of the study is on the diffusion process and the factors which accelerate or delay this process. Perception and behaviour of the decision-making units are crucial elements of the process. To be able to use the DOI as an analytical framework, qualitative data is needed. For this thesis these data were not available. The DOI also addresses the comprehensiveness, complexity, and effectiveness of the innovation itself to a lesser extent. Once the innovation is formed, well-designed, proven to be effective and ready to be diffused, then such a framework could be one of the best methods for the analysis.

2.3.3 Justification of the selected analytical framework

After considering existing alternative options for the structured analysis, the decision was taken to continue with the model as shown in Figure 1. An effective CSE program is a multisectoral achievement. This is a combination of interlinked elements, which complement each other and ensure the quality of education and health services. The main questions of this thesis are how do the systems respond to adolescents' sexual and reproductive health needs? What is already in place? and what is lacking, and why? The proposed analytical framework can guide this analysis in a structured way, and examine the challenges, opportunities and complexity of the health system response needed for CSE.

3 STUDY RESULTS

3.1 Sexuality Education in Tajikistan. What is known about it?

Only a limited number of papers were found regarding the development of CSE in Tajikistan. Most of the search results were captured in the reports of international development partners, such as UNESCO, UNICEF, and UNFPA. As a second step, the search with the same keywords was repeated in the Russian language. In addition to the previous results (reports of international partners, but translated into Russian), some opinion papers or theses mentioning SE were found. However, even with this extended search, the number of peer-reviewed articles about SE in Tajikistan remained very limited.

In reality, any formal SE in the post-Soviet states, including Tajikistan, only became possible after their independence in 1991. In addition, shortly after the collapse of the Soviet Union, Tajikistan was devastated by a civil war from 1992 to 1997. The war resulted in both heavy economic and human loses, followed by a long recovery period. It is understandable that with such a history, educational and health reforms, including SE developments, only became possible after the year 2000. The first National Law on Reproductive Health and Rights, where healthy lifestyle education (HLSE) was mentioned, was adopted in 2002 (31). Starting from that year, SE, as part of HLSE, gradually starts appearing in the activity reports of (international) development organisations operating in the country.

In 2014, the German International Development Agency (GIZ) made an analysis of all National SRHR and HIV strategies and legislation which were available in Tajikistan at that time (32). This included the components of SE or HLSE, and reproductive health (RH) services available for adolescents. The author concluded that although health education

has become more important in Tajikistan, the main focus of the SRHR strategies remains on reproductive health.

One of the crucial international reports capturing achievements in the field of SE in Tajikistan was published in 2018. Being a country in the WHO European Region, Tajikistan was included in a systematic assessment of the status of SE program in Europe and Central Asia (11), (33). This report covered five fields: 1) Law and policies; 2) Implementation of SE; 3) Opposition and barriers; 4) YFHS; 5) Research data on adolescent SRH.

The report was based on the responses of governmental and NGOs involved in SE in Tajikistan. The primary respondent for Tajikistan was the Tajik Family Planning Association (TFPA), a member of IPPF European Network (IPPF EN). According to this report, Tajikistan has made significant progress in the area of SE: sufficient legal basis for the provision of SE some elements of which have been integrated into the HLSE in five regions. Cultural taboos related to sexuality, as well as insufficient financing, were mentioned as the main challenges in implementing SE programs.

The above-mentioned reports were the starting point and further investigation was done using the annual reports of in-country UN development partners, NGOs, local civil society organisations (operating in the area of HLSE in Tajikistan), legislative frameworks, periodic program reviews and assessments of national strategies. The findings from the desk review were triangulated and enriched with the contributions of KIs.

BOX 3. List of the Reviewed National Strategies and Laws

National Youth Law (2004), National Youth Policy (2006)
National Strategy for Children and Adolescent Health 2008-2015 (2008)
National Health Strategy 2010-2020 (2010)
National Education Strategy 2020 (2012)
National Education Law (2013)
National Development Strategy 2030 (2016)
National HIV Strategy 2017-2020 (2017)
National Law on Reproductive Health and Rights from 2002 (updated 2015)
National Health Law (updated 2017)
National Strategy for The Reproductive Health 2019-2022 (2019)

3.2 Components of Sexuality Education Program. Adoption and Implementation.

In this part, each element of an effective CSE program, as defined in 2.5 Choice of Analytical Framework, will be described based on the findings from the literature review, including any additional information from KIs.

3.3 Enabling Environment

3.3.1 Analysis of the National Strategies and Policies for Adolescent Reproductive Health and Rights, Including Provisions for Sexuality Education.

The creation of an enabling environment and a national legislative framework, aimed at the recognition of needs and rights for SE, is the crucial starting point for an effective CSE program. Favourable policies and political commitments contribute to the prioritisation of the adolescent health program, ensure accountability to this population group, and enhance progress in this area. However, the development of a clear, well-functioning, national policy, which is aligned with international standards, takes time. It is also highly dependent on the national political climate, economic priorities, perceived needs and cultural sensitivity.

An analysis of the broader context of reproductive health (RH) and the rights of adolescents and youth was conducted to understand the national policy for SE. In this sub-chapter, six major strategies and four national laws were analysed. The goal of this exercise was to

understand how current legislation and policy influence adolescent SRHR, including the implementation and effectiveness of the SE program in country (BOX 3).

As mentioned previously, a similar analysis was conducted in 2014 concerning the existing SRHR and HIV policies at that time (32). This review builds on earlier findings. However, it further considers new strategies with a narrow focus on adolescents, healthy lifestyle (HLS) and SE. This approach allows the dynamics and trajectory of the developments in this field to be determined. The analysis was undertaken in chronological order.

Tajik **National Youth Law** from 2004 and **National Youth Policy** from 2006 identify youth as individuals aged 14-30 and prioritise and guarantee their full rights to health and education (34). Youth Policy has a cross-sectoral nature. The Committee of Youth Affairs was assigned as a governmental agency responsible for the implementation of the policy.

The **National Strategy for Children and Adolescent Health,** was realised between 2008 and 2015 (35). This strategy identified ASRH as a point of particular concern. It recognised a rapid increase in HIV and STIs among people under the age of 30 and an insufficient response by the health system caused by inadequate financing. However, areas and components of ASRH are not defined as such, which might affect the program's effectiveness. The term *adolescent* refers to young people aged 10-18 years, and in section "5.4 Adolescent health" three result areas deal with ASRH: prevention of risky behaviour, control over the number of teenage pregnancies, and access to YFHS. A key focus was placed on the relevance of RH education. It was planned to update the HLS curriculum (before 2010). The targets for 2015: Two-thirds of the secondary schools should have introduced life skills education; 60% of adolescents should be informed how to prevent early pregnancy and STI transmission; at least 30% of all adolescents should make use of YFHS; 50% of adolescents should know at least three modern contraceptive methods. The results are measured by monitoring the percentage of alcohol and drug consumption, the number of trained health workers addressing adolescent's health needs, and the number of teenage pregnancies.

The analyses show that there is a lack of clarity on the expected service package for YFHS and whether these include consultation on contraception for minors, sexuality, gender aspects, and how the efficiency and effectiveness will be measured. No strategies recognising the vulnerability and special needs of rural adolescents (73% of all adolescents) in terms of access to SRH services and information are discussed, which could lead to increased inequalities.

Despite multiple attempts to find the text of the successor program for children and adolescent health, by using both open internet resources, as well as own professional network, these efforts were not successful. According to some KIs, when this program came to an end in 2015, children and adolescent health strategies were integrated into the broader national strategy to avoid fragmentation.

Some adolescent SRH components are mentioned in the **National Health Strategy 2010-2020** under 'Strengthening Maternal, Newborn, Child and Adolescent Health' (36). This strategy was developed and approved in 2010 and in line with adopted UN Declaration 'Achieving the Millennium Development Goals by 2015'. This strategy emphasises that a shift from curative to preventive public health interventions is needed. *Education on reproductive health*, family planning, safe motherhood, STIs and HIV/AIDS should become part of the health curricula at schools and part of the community outreach. It should also support young people in their development, their acquisition of social skills, promote a HLS, and support their access to YFHS.

The strategy focuses on several specific areas. First, a *holistic approach to the reproductive health of girls* and their improved access to family planning services. Second, HIV prevention among vulnerable groups, including full use of YFHS. The strategy implies

technical support (inter-agency collaboration) to the educational sector regarding the content of the HLSE. However, the observation was made, that these statements are not translated into any specific national target or indicator for adolescent health at the end of this document.

Older adolescent girls are included in the group of women of reproductive age 15-49 years. This generalisation might challenge the monitoring and progress towards global commitments to adolescent health, as well the domestic financing for adolescent health and accountability to this group in particular. However, including girls aged and above in this group, ensures their right to access SRH services.

The **National Education Law** from 2013 doesn't have any specific provision on health education (37). It mentions only that the teacher should promote HLS among students. The **National Education Strategy until 2020** (2012) emphasises the importance of quality education which includes the development of life skills and healthy lifestyle. Still, the strategy doesn't elaborate any further details on its implementation (38).

The **National Development Strategy 2030** (2016) includes political commitments to the SDGs agenda and defines among others health care, education and demographics as priorities of the national development (39). Despite the progress of the last decennia, poor quality of health services and education are described as a challenge. With respect to health, high maternal and neonatal mortality, HIV/AIDS, STIs are still considered persistent problems. Universal access to RH services, including the improvement of *reproductive literacy* is linked to the demographic window of opportunity, human capital management and long-term economic development. A *healthy lifestyle* is described as a factor contributing to health status and quality of life. Gender equalities and violence against women and girls are points of special attention, as well as the elimination of social inequalities. The development of an adequate legislative framework and national programs preventing violence against women and girls have been mentioned as a strategic priority.

The National Health Law (2017) guarantees the rights of adolescents and youth to their reproductive health (40). It recognises the right to SE and RH care services. The curriculum development is being seen as the joint responsibility of health and education authorities. According to legal language, protection of RH and the *preparation for marriage and family life* are the main objectives of SE. It should be age-appropriate and based on morality and ethics. Well-trained professionals should provide this type of education through the education system or in the health care facilities.

The **National HIV Strategy 2017-2020** (18) includes youth as a group vulnerable to HIV, prioritising the preventive education at schools and supporting existing YFHS. It also underlines that every fourth person with a confirmed HIV status doesn't seek medical health care because of stigma, poor knowledge about risks associated with the transmission and perceived discrimination. The National Coordination Committee on HIV/AIDS includes a thematic group on information, education and communication, and works closely on prevention with the National Youth Committee. The plan is that by the end of 2020, 100% of the 9-11 grade school children (the last two years of secondary school, approximately 15-18-years-old) and 70% of first-year high school students have received education related to HIV and associated risks. However, the HIV program with an average annual budget deficit of 60%, has minimal resources (approximately USD 200,000 yearly) to support activities for adolescents and youth.

In 2019 the government of Tajikistan approved **The National Strategy for The Reproductive Health 2019-2022** (41). Earlier in 2015, the amendment to **The National Law on Reproductive Health and Rights** from 2002 was adopted (Article 13, 20), allowing minors and youth to exercise their rights for RH. It includes access to *sexuality and family-life education*, as well as to the (youth-friendly) RH services (31). Parental permission is needed for the provision of abortion services for the minors. The National

Strategy for The Reproductive Health builds on this amendment, making modern contraception methods and consultations available for free for women at reproductive age (15-49 years) without restrictions. The objectives of the strategy: to improve quality and access to RH care and family planning, decrease maternal mortality, improve supply chain management and financing, and to provide RH education (41).

This strategy has been aligned with Target 3.7 of the Sustainable Development Goals: By 2030, ensure universal access to SRH care services, and integration of RH into national strategies and programs. The achievements in this area will contribute to 1) Indicator 3.7.1: Proportion of women of reproductive age (15-49 Years) who have their need for family planning satisfied with modern methods, and 2) Indicator 3.7.2: Adolescent Birth Rate (10-14 and 15-19) per 1,000 women in each age group (10-14 and 15-19).

This review of national laws and strategies of Tajikistan proves that in recent years significant progress has been made in terms of policies and legislative framework for HLSE. The need for SE and HLSE is being reflected in health-related strategies. It is being seen as one of the priority interventions to address the SRH needs of the younger generation. Selected topics related to SE can be included in HLSE. However, HLSE is not compulsory and is considered an extracurricular subject.

Nevertheless, the policy language on the components of HLSE is not elaborated sufficiently and rather vague. It doesn't provide a strategic direction for action, which allows room for misinterpretation. One of the KIs reported that this is one of the reasons why the implementation of the curriculum-based HLSE is rather hard to realise, promote or advocate among decision-makers.

"Regarding sexuality education, there are areas where we have made progress, there are areas where we are at a standstill, and there are areas where we are, unfortunately, regressing. Quality education is a high priority for the government, as well as population health, especially maternal and reproductive health. But including topics like sexuality, condom use, and gender in the school program is very challenging. A clear policy which needs to be included in the curriculum, is missing. Teachers, even if they dedicate time to these discussions, choose only for 'comfortable' topics to avoid any confrontation. The focus of HLSE was always on personal hygiene, daily physical activities, HIV prevention and family ethics." (KI).

Updates in the National Law on Reproductive Health and Rights and the newly approved National Strategy for Reproductive Health contribute significantly to the positive developments in the area of adolescent RH. The legislative framework provides adolescents and youth with the right to SRH. However, it needs to be stressed that the holistic approach to SRHR and CSE has been limited to the protection of RH and access to YFHS. Aspects, such as sexuality, gender expression, rights and non-discriminative approach to SRH, alignment with the international standards have unclear character and lacking specificity.

Even with the extracurricular character of the SE, development of the content and implementation, the HLSE is still a shared responsibility between the Ministry of Health and Wellbeing and the Ministry of Education. International development partners and NGOs play a crucial role and support the ministries with all aspects of effective SE. Currently, the main players are UNFPA, UNESCO, WHO, IPPF and Y-Peer, and their interventions and contributions to the SE program will be described in the results section.

3.4 Content of the curriculum for sexuality education

Policies on SE and enabling environment are closely linked to the comprehensiveness of the content for the SE.

As already mentioned, national health and education laws do not obligate schools to include HLSE in the curriculum, however healthy lifestyles can be discussed during so-called *classroom hours* - about 5-8 hours annually, depending on the students' grade.

Drafts of updated textbooks for a HLS were received through the KIs. At the time of writing this thesis, the final or printed versions of the textbooks were not available to the author. However, according to KIs, the content of all components has been approved by the Ministry of Education. Training-the-trainers has been developed in line with these versions. Therefore, the available drafts of The Healthy Lifestyle training manuals for students in grades 10-11 of secondary school were reviewed.

The manuals were developed in collaboration between The Ministry of Education, UNFPA and the NGO "Peer to Peer" (Y-Peer Network) and are in line with the national education strategy and national program for the promotion of a healthy lifestyle. They aim to raise awareness about the risks of HIV/AIDS and support adolescents in making informed choices, including the acquisition of life skills, correct knowledge and attitudes about health, relationships, social norms, responsibilities, morals and ethics.

The program for 15-17-year-old adolescents (10-11 grades students) was compared with the WHO Standards for Sexuality Education in Europe, which correspond with stage 4-5 (puberty and on the cusp of adulthood) (14). The manuals were assessed and the content and topics on SE were analysed. For this age range, the WHO recommends general themes, such as the human body and human development, fertility and reproduction, sexuality, emotions, relationships and lifestyle, health and well-being, sexuality and rights, social and cultural determinants of sexuality (values/norms). These are specified according to the parameters of knowledge, skills and attitudes. The review of the learning materials revealed the following (Table 4):

Table 4. Assessment of SE themes included in the Healthy Lifestyle manuals for 10-11 grade students in Tajikistan (based on the WHO Standards for SE).

A **Themes for 15 years and up (as recommended by WHO Standards for SE)**	**B** **Information (give information about)**	**C** **Skills (enable teenagers to)**	**D** **Attitudes (help teenagers to develop)**
The human body and human development	• Special stage in human physical and psychological development	• Recognise the changes; • Communicate about the changes	• Acceptance of the changes • Positive self-esteem
Fertility and Reproduction	• Family ethics; • Maternal and neonatal health; • Responsible parenthood; • Men and women equal rights and responsibilities to parenthood; • Family planning; • Birth rate and birth interval; • Contraception; • Risks associated with the early pregnancies, abortion for the future RH;	• Make an informed decision regarding contraception and the number of children; • Use negotiation skills; • Understand the reproductive rights; • Seek help in case of unsafe sexual activity	• Awareness regarding risks associated with the early pregnancy, number of children or abortion; • Awareness regarding a mutual responsibility for fertility and reproduction question; • A positive attitude toward family and parenthood

	• Drug use, smoking, alcohol, and RH; • RH and rights; • RH and well-being; • Access to the reproductive services		
Sexuality	-	-	-
Emotions	• Awareness of differences between emotions and ways of expression (love, friendship, jealousy)	• Respect, Confidentiality and privacy	• Acceptance of the different feelings, thoughts, ideas
Sexuality and Rights	• Concept of right-holders (related to reproduction health: rights to information and rights to health)	-	-
Sexuality, health and well-being	• Risky sexual behaviour and the impact it can have on health; • HIV/AIDS and STI transmission, risks, prevention; • Sexual violence, human traffic; • Early pregnancies, risks • Family planning, birth interval; • Link between physical, mental health and well-being (holistic approach to health); • Body hygiene and self-examination; • Access to health care (lab services, regular monitoring of health status); • Link between informed decision and health outcome; risky behaviour and physical, social and mental well-being	• Develop a proactive health-seeking behaviour; • Increase health literacy	• Responsibility for the own health
Relationship and lifestyles	• How to develop and maintain relationships; • Recommendations on the safe premarital relationships; • Expectations and misunderstandings; • Right to say "no"	• Negotiate your relationship (level of intimacy); • Seek a well-balanced relationship	• Acceptance and respect of different types of premarital relationships
Social and cultural determinants of sexuality (values/norms)	• The influence of peer pressure; • Abstinence as a preventive measure to avoid unwanted pregnancy, stigma, STIs;	• Avoid risky behaviour • Keep cultural values • Defend your choice	• An awareness of social, cultural and historical influences on sexual behaviour; • An appreciation of self-esteem

	• Abstinence is a responsible choice based on cultural values; • Gender-related stereotypes		

In this table Column A reflects the topics, as recommended by WHO for this age group. Column B indicates which and how the information has been covered in the reviewed manuals. Columns C and D show to which life skills and attitudes this information is contributing, according to the authors of the manuals.

From the analyses conducted, it can be concluded that the protection of adolescent RH is the main focus of SE at this stage. The primary focus is on preventive measures, such as education on HIV/AIDS, STIs, the risks associated with the transmission and consequences of risky behaviour for the health of both future parents and children. Drug use, alcohol and smoking are contributing to sexual risky behaviour. Abstinence before marriage is often cited as the best preventive measure to avoid problems with RH. Cultural values and norms regarding sexuality support abstinence or *self-control*; healthy families, family ethics and morality play a central role. This focus was also repeatedly stressed by the KIs during the interviews. These manuals do not forbid adolescents from being sexually active but stress that this behaviour can lead to social stigma, violence, human trafficking, health problems and poor well-being.

Nevertheless, the manuals give answers about what to do in the event of unsafe sexual activity, and how and where to seek help. Condom use is mentioned as a way to protect against HIV infection. A holistic approach to health and well-being is well-elaborated and supported by quotes from the medieval Persian philosopher and physician Avicenna, who is highly respected in the country.

As can be seen in the table, the content on *sexuality, sexuality and rights* with the WHO recommended information on sex, sex and gender, gender expression, positive approach to sexuality, sexual rights and its violation, and discrimination are still missing in the reviewed manuals. In this regard two of the KIs stated:

"Sexual orientation and gender expression are very sensitive topics in society. It took us years of preparation and negotiation with the decision-making authorities regarding the need to include such neutral topics as contraception, STIs, and condom use into the manuals for students. It was a big achievement. However, it is still unfinished business. Step-by-step, we will work on and advocate for more comprehensive content on the curriculum." (KI).

"Students at school are not being exposed to such in-depth information about variations in sexual orientation and gender expression. Traditional family values and faithful relationships are being promoted." (KI).

According to the Tajik education system, students can leave school after the 9th grade. In 2020, about 56% of students made this choice. If SE is only available for 10-11 grade, this means that these students do not receive any SE.

3.4.1 Sexuality education outside school

In the absence of formal SE in Tajik schools, UNESCO IITE, in collaboration with the Tajik public organisation Hamsol ba Hamsol ("Equal to Equal", Y-Peer network [1]), launched a web-based resource dedicated to health and relations, called "Comprehensive About Relationships and Love" (available through http://y-peer.tj/all-about-relationship-and-love/).

Alongside advice on healthy lifestyles, this open-source resource provides information on contraception, family planning, HIV prevention, gender-based violence, stigma, reproductive systems, physical and psychological changes, trustful relationships, friendship, life skills, mental health, the risks of drugs and alcohol abuse. Social media channels such as Facebook and Instagram, are being actively used to support the website content.

In an interview, a KI from this organisation mentioned that the provision of correct and adequate information related to SRH is one of the main objectives of their work.

"Our experience shows that the correct use of internet resources is a skill. It is not always easy for young people to separate facts from fiction. Especially when a young person just starts using the internet. They are prone to misinterpreting information, especially in such delicate topics as sexuality." (KI).

The KI also confirmed and recognised that the information provided via their website focuses on RH and the prevention of STIs. The information provides answers about risky behaviour and its possible consequences and teaches young people to act responsibly. Although abstinence before marriage is encouraged, there is no restrictive language observed regarding sexual activities for young people.

Further, Hamsol ba Hamsol, with the support of international donors, organises training for adolescents to build their capacity and life skills. They are involved in peer-to-peer outreach activities and advocate for equal opportunities.

3.5 Appropriate teacher training

Another essential element of an effective CSE program is adequate teacher training.

KIs involved in the implementation of SE and training of teachers reported that the most common challenges for the teachers in Tajikistan are a lack of dedicated time and appropriate knowledge about how to deliver sensitive topics.

As mentioned earlier, HLSE is not yet included in the compulsory school curriculum at this stage. UNFPA, a development agency together with the Ministry of Education, are involved in updating the HLS manuals, their introduction and roll-out, including the training of teachers in pilot sites.

According to the UNFPA Country Program Document for Tajikistan 2016-2020, UNFPA works on prioritising adolescent health, including the availability of CSE (42). By the end of 2020, 10% (320 schools) of all secondary high schools in Tajikistan should adopt HLSE following international standards for grades 10 and 11. The baseline in 2016 was zero schools. A KI from UNFPA reported that in 2019 alone, they succeeded in training about 70 out of the 320 teachers from the four biggest cities of the country. However, *"The*

[1] Y-PEER Tajikistan was initiated by UNFPA in Tajikistan in 2007 and was registered as NGO in April 2012. Official name**:** NGO 'Hamsol ba Hamsol' (Y-PEER Tajikistan)

attitude of teachers toward SE remains a difficult topic. Younger teachers show less conflict with personal beliefs regarding adolescents' sexuality than the older generation of teachers. The endorsement of the school management and the availability of a support system for teachers enable the provision of sexuality education." (KI).

The involvement of medical staff from YFHS is possible. However, it depends on the proactivity, interests and vision of the school management and individual teachers towards these questions. It often also involves additional permissions from higher authorities.

"When our organisation works with medical staff from the Reproductive Health and Family Planning Centre or YFHS, especially in the remote regions, we see their willingness and enthusiasm to provide additional advocacy and lectures in schools. Even in their free time and without pay. It is based on their evidence and experience regarding girls' poor knowledge, attitudes and health-seeking behaviour. Delays in treatment and poor health outcomes justify the need for more action. School is the best place to address adolescents RH. But a lack of clarity on whether or not it is allowed and obtaining permissions stops these individual initiatives. But we also know of cases, where school authorities take full responsibility, invite medical staff and allow extracurricular activities and the provision of the age-appropriate information." (KI).

Given the fact that HLSE has a very limited number of available hours, UNFPA has been looking for alternative methods. For example, integration of some topics, such as gender or HIV, with the related compulsory school subjects, such as family ethics or anatomy. A KI underlines that investigating the experience of other countries would be useful.

It is important to mention that in 2019, with the support from the Ministry of Education and Science, UNESCO in collaboration with UNFPA and the public organisation Equal to Equal (Y-Peer Network) organised a sub-regional expert meeting in Tajikistan on "Reproductive health and healthy lifestyle education among young people in Central Asia and Eastern Europe" (43).

Most of the post-Soviet countries have common challenges related to the comprehensiveness of the curricula, quality of the sexual health education, acceptance and the delivery of information. The meeting an opportunity for educators to exchange knowledge, as well as to jointly search for solutions. The recommendations to national educational authorities show the areas which require special attention in all countries, and include the following:

- Compulsory status of the SE at all levels of the educational system;
- Accountability of the school management for the implementation;
- An increased amount of time dedicated to SE, not less than 16-32 hours;
- Comprehensive curriculum, which should include gender violence, HIV stigma and discrimination, early pregnancy, STIs;
- Community involvement, youth participation, and peer education practises;
- Adequate training for teachers and the availability of interactive materials and schoolbooks;
- Ongoing advocacy for the implementation of SE among decision-makers and educational authorities;
- Availability of pre- or in-service training for the educational workforce;
- Availability of internet resources with accurate, age-appropriate CSE information for students;
- Availability of online training platforms for teachers, including regional-specific informational hub and knowledge exchange centre;
- Option to involve health workers in the educational process on RH, including appropriate training;
- Special attention to education staff in rural and remote areas;

- Standardised monitoring system;
- Parallel work with parents to increase their understanding of the objectives of the CSE program and to accelerate interpersonal support (parent-child).

Based on this outcome, specific steps for the development of HLSE in Tajikistan were recommended to Tajik education authorities by the technical working group of this meeting. First, program scaling-up and adherence to international standards on health education (training of education staff, monitoring of effectiveness and implementation). Second, a compulsory status of HLSE and its prioritisation in the new National Strategy on the promotion of a healthy lifestyle in The Republic of Tajikistan 2020-2030 (44).

UNESCO stresses that the organisation of such meetings in Tajikistan and the active participation of the Tajik education and health authorities show their strong commitment and interest in the objectives of HLSE in the country. The organisers also hope that the involvement of Tajikistan in regional developments will give the necessary boost to prioritise RH education in schools and will facilitate further adoption of the SE program.

In addition to what was described above about current developments in the area of teacher training, it is important to mention previous achievements in this area in Tajikistan.

In preparation for the interview with the KI representing the Tajik Family Planning Association (TFPA) the member of IPPF EN, their local website was studied. It was observed that the HLSE teaching manual and school books for 7th, 8th, and 9th-grade students were available to download for free (45). These textbooks, as manifested on their cover pages, were developed and approved in collaboration with the Ministry of Education, and with support from UNESCO and the Global Fund in 2008. They describe and emphasise the holistic approach to (reproductive) health and elaborate in detail the benefits and needs for HLSE in Tajikistan. Further, these resources provide best practices, give comprehensive, age-appropriate information on most topics of SE, such as the reproductive system and health, HIV, STIs, risky behaviour, contraception, and also provide interactive and participatory training on life skills, and link these topics to the available YFHS in the country. The role of family and the cultural aspects of marriage are taken into consideration. Unfortunately, the author could not find any current program or project which implements HLS based on these manuals. As reported by the KI:

"The HLS education based on this curriculum [available manuals on the TFPA website] for younger adolescents 13-15-years-old were developed and later introduced in some pilot sites. The scaling-up process and financing of the pilot sites were based on the availability of funds and the donors' plan and vision of the development work. The effectiveness of HLS education for this population was shown in the project results and reported to the governmental decision-making bodies. Unfortunately, due to the limited financing of the National HLS Program, the sustainable transition from donor to local ownership has not taken place. That is why if adolescents or teachers still want to make use of the available materials on HLS, they are free to do it via the TFPA website." (KI).

3.6 Contextualised delivery

Contextualised delivery refers to the needs-based, learner-centred provision of SE. It interlinks with teachers' skills, their motivation on the one hand, and with the content of curriculum and delivery methods on the other. To be effective, the SE program should be adjusted to the country context, the needs of the target population and where the educators get adequate support and training (12). Developing the competencies for the quality delivery of SE programs is a continuous process with preparation, implementation and follow-up phases (46). Not only training is of crucial importance, but also an enabling school environment and support from communities (47).

In Tajikistan, at this stage, HLSE is only being introduced and implemented in selected pilot sites, involving approximately 10% of the schools in the country, and the development of SE has just started. Therefore, once the pilots finish, evaluations are needed. These evaluations should include qualitative studies on how both students and teachers perceive the content, methods and supporting systems inside and outside schools.

3.7 Youth-Friendly SRH Services - "Youth Cabinets"

As shown in 3.2.1 Enabling environment, The National Strategy for Reproductive Health 2019-2022 is one of the latest documents in the area of SRHR, linking the need for HLSE with access to YFHS. This access is guaranteed by the national law and is free of charge. Access to contraception and RH services for women of reproductive age (15-49 years) is explicitly elaborated. Earlier, the link was made between the effectiveness of a CSE program and available and accessible YFHS, as suggested by the leading technical agencies (12), (14), (27). In 2012, a study published on the role of SE and YFHS and their association with improved youth sexual health in Estonia (48), concluded significant improvements in sexual health indicators and its causal relationship to the parallel development of both SE and YFHS. The involvement of the same agencies in the development and implementation of both processes is a contributing factor to these positive results.

In Tajikistan, under the leadership of UNICEF and with a number of international, local collaborating and implementing partners, 21 YFHS, or, so-called "Youth Cabinets" were established between 2006 and 2013. They cover 12 districts in 5 regions, including the capital city (49). However, the centres are only located in the urban areas of the country, which might affect access by rural youth. According to the UNICEF evaluation report, a lot was done to ensure the sustainability of the centres after the end of external funding. UNICEF has facilitated a fiscal space analysis for the more rational use of governmental funds for primary health care. The optimisation of public spending has allowed the redirecting of resources to YFHS. As a result, the share of government funding has increased over the years and ensured a sustainable transition to local ownership. At this point, all YFHS have been funded by the Government of Tajikistan, including 25% of the cost of commodities, such as contraception. KIs have confirmed that among other services, young people can get HIV and STI testing, consultation on contraception methods, and psychological support. However, the underutilisation of these services among adolescents remains a problem.

Back in 2014, the UNICEF Program Evaluation Report underlined that although YFHS have proven to be effective and efficient, and the link with the educational system was established, the YFHS program has failed to get higher numbers of clients referred from the pilot sites. When addressing this question, the KIs agreed that, in their opinion, the demand for YFHS among adolescents and youth is still low. At the same time, clients from marginalised and vulnerable groups make better use of existing YFHS. During the interviews, when they were asked what, in their opinion, were the reasons for the low utilisation of YFHS, the answers were based on assumptions, as no formal research has been conducted on the health-seeking behaviour of young people concerning YFHS:

"It could be a problem with access, as only bigger cities have YFHS, inconvenient working hours of the facilities, poor visibility, lack of knowledge among key populations that these services exist, perceived costs, stigma related to the sexually active adolescents. It could be everything, at this point we cannot provide a clear answer on this." (KI).

To address the low utilisation of the "Youth Cabinets", TFPA, in collaboration with the national and international partners, developed and launched a mobile phone application in

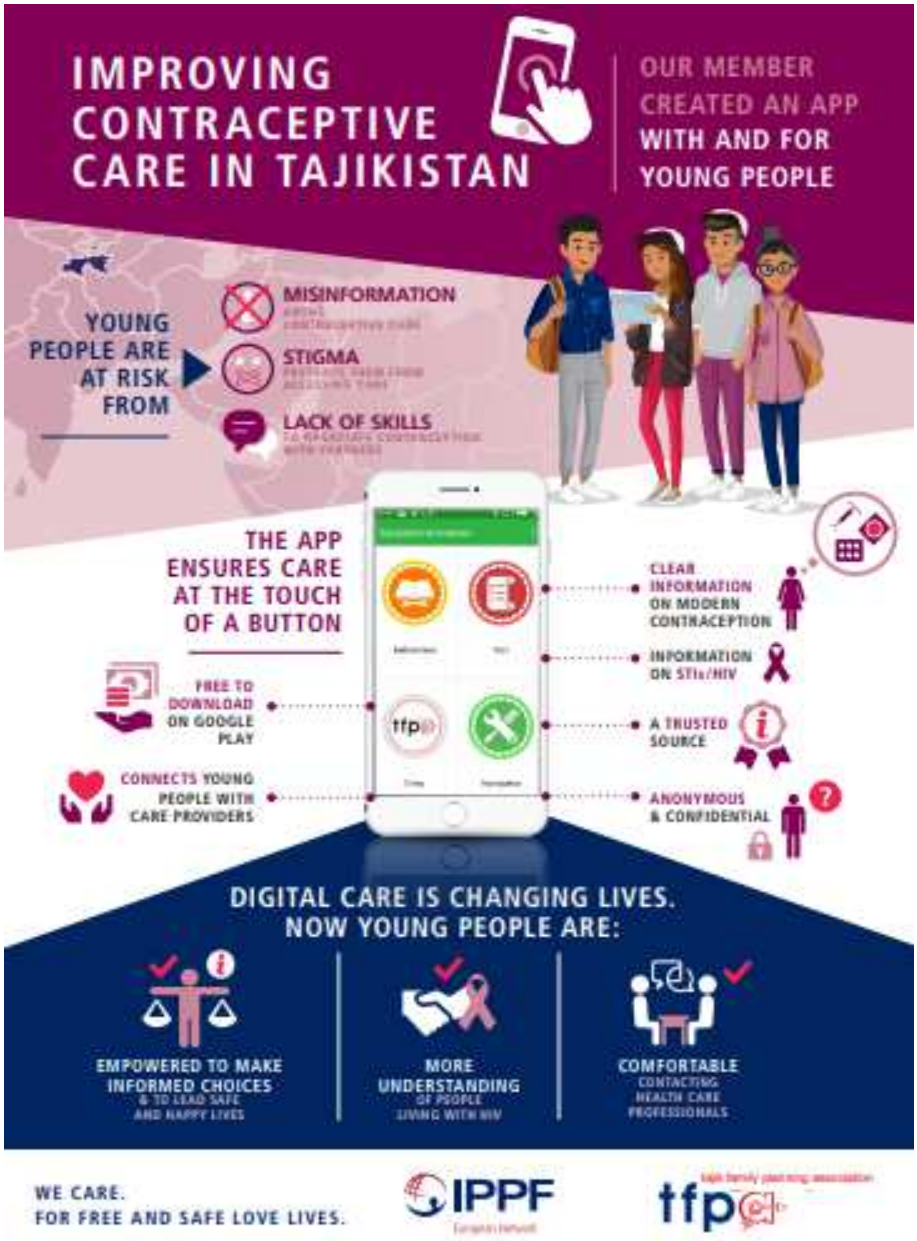
2016 called "Healthy Youth". This application is available for free via the website of the organisation (45). A review of the application content showed that it provides comprehensive information regarding HLS in general. It has detailed and illustrated content on male and female reproductive systems. It also addresses types of STIs, including HIV and the risks associated with transmission. The application provides information on the advantages and disadvantages of the different contraception methods and there is also a "help" button which displays where and how to get services related to SRH (addresses, phone numbers of YFHS across the whole country).

The application was created with and for young people, and tested among 580 participants from the key population (16-24 years), it has proved to be effective in increasing the acceptability of contraception among young people in Tajikistan (50).

As reported by the KI from TFPA, information about this application is being spread among young people through volunteers, and more and more people are making use of it. TFPA is planning to analyse the usage of the application, such as most visited sections, the geographic location of downloads, and the proportion of male and female users, in order to adjust the content and visibility appropriately.

In BOX 4 the infographic about this mobile phone application is shown. As observed from the review of the content, this mobile phone application contributes to a safe, stigma-free learning environment for SRH, whilst also supporting extracurricular SE and facilitating links to YFHS in country.

BOX 4: IPPF/TFPA Infographic on the Mobile Application for Youth (Source www.ippfen.org)



3.8 Barriers for adoption and implementation of an effective sexuality education program

The barriers which delay the adoption of SE are supposed to be considered within the section about the enabling environment. The choice to mention it at the end of the results section is motivated by the cumulative character of the disablers. When analysing the findings, the following factors can be identified as barriers:

1) Resistance to SE caused by the cultural climate and religion. Resistance affects the decision-making process at the policy level, the comprehensiveness of the content, and acceptance of SE in general. KIs recognised and confirmed that this is still a challenge for the country. SE is wrongly perceived to accelerate the start of sexual activities and expose adolescents to risky behaviour. Time and ongoing advocacy are needed for HLSE to be fully formalised, including topics on sexuality and RH. Advocacy in this area is an integrated part of the development agenda of international partners.
2) Lack of adequate financing. International development partners and NGOs fund and deliver most of the health education programs in Tajikistan. This dependency on foreign aid jeopardises the sustainability of these initiatives once external funding ends. This may be one of the underlying reasons why HLSE is not compulsory, as formalisation would involve significant investments in the pre- and in-service training of teachers and additional funds for implementation. It might not be the priority for the current reforms in the education system of Tajikistan.

4 DISCUSSION

In this section, the major findings of the thesis are discussed within the elements of an effective CSE program, as suggested by the chosen analytical framework: The enabling environment in which CSE program in Tajikistan has been provided, the content of the curriculum, the availability of the appropriate training for educators and YFHS, and necessity for a needs-based approach.

Enabling Environment

The review of national laws and strategies of Tajikistan proves that in recent years significant progress has been made in terms of improvement of policies and legislative framework for ASRH. The need for HLSE, including sexuality aspects, is being reflected in a number of health-related strategies and laws, as well as in education programs. Increasing health literacy and risk awareness are being seen as priority interventions to address the SRH needs of adolescents.

Updates in the National Law on Reproductive Health and Rights and the newly approved National Strategy for Reproductive Health (2019) contribute significantly to the positive developments in the area. They provide adolescents and youth with the right to SRH care services and are aligned with the *SDG Target 3.7. Universal access to SRH care services*, including those for family planning, information and education. This is a constructive and significant step forward.

However, it needs to be stressed that the manifested holistic approach to SRH and CSE has been mostly limited to the protection of RH. Aspects such as sexuality, gender expression, rights and a non-discriminative approach to SRH, and its alignment with international standards are unclear in character and lack specificity. In addition, in previous national strategies, little is translated into specific national SRH targets or indicators for adolescent SRH. Current policy language on the components of HLSE is not elaborated sufficiently and rather vague. It fails to provide a strategic direction for action and allows room for misinterpretation, which might cause delays at the implementation level and affect the effectiveness of the program. Despite all the progress made on the legislative and policy level, SE is still not compulsory. This is a major factor preventing the further adoption and spread of the program in the country.

At the same time, three main national strategies, namely, the Health Strategy (2010), the HIV Strategy (2017) and the Education Strategy (2012) come to an end in 2020. An update of these strategies is an opportunity for more progressive, clear and aligned language on HLSE, its status and components, implementation, and responsibilities.

Although an analysis of funding sources for the SE program was outside the scope of this thesis, it is still important to mention challenges related to this aspect. Studied strategy documents and reports from implementing partners show that the adoption and implementation of a SE program are highly dependent on external funding. KIs also expressed concerns about this, confirming that it jeopardises the sustainability of activities in this area. Development partners are financially involved in nearly every aspect of the program development and implementation, as well as curriculum updates, training of trainers in the pilot areas, advocacy and peer-to-peer education.

However, the success story related to YFHS and its sustainable transition to government ownership demonstrates that is it possible and shows how the fiscal space can be optimally used.

Content of Curriculum

The available teaching materials for HLSE for 10-11th grade students (15-17-year-old adolescents), include SE topics which are in line with the current national health strategies and national program for the promotion of a healthy lifestyle. They are focused on the protection of adolescents' RH and awareness of risky sexual behaviour. Cultural values and norms regarding sexuality are explained, as well as abstinence as the preferred choice for a healthy family life. Nevertheless, the manuals do give answers on what to do in the event of unsafe sexual activity, and how and where to seek help.

A selective approach to topics offered for discussion and an observed lack of such topics as *sexuality and rights,* positive approaches to sexuality, sex and gender, as well as gender expression, compromise the comprehensiveness of the SE program. They reduce the program's effectiveness, and additionally, may even stigmatise adolescence sexuality and sexual diversity.

Unfortunately, as already mentioned, financial constraints have resulted in the discontinuation of the earlier pilot programs targeted at SE for younger adolescents (10-15-years-old).

Appropriate training for educators and need-based approach

The non-compulsory nature of HLSE, including SE, means that schools are not required to provide it, and educators are not obligated to be trained in this subject. The attitude of teachers toward SE remains a difficult topic: breaking the taboos around sexuality often conflicts with their personal beliefs. This means that even if a schoolteacher discusses HLS with students, they are free to choose the topics and ways to present sensitive information. This approach may lead to either incomplete or even incorrect delivery. Further, the limited number of extracurricular hours available for SE is not enough for the already approved SE topics to be comprehensively delivered, which can affect the quality of education.

The active involvement of Tajikistan in the WHO Europe regional developments related to SE has had a positive effect on the priority setting of health and education authorities and can facilitate the further spread of the SE program. The position of the school management and the availability of a support system for teachers will further stimulate the provision of SE.

Newly introduced innovations, such as mobile phone applications or informative online platforms for SE, with an established connection to YFHS, can increase the visibility of available SRH care services and provide adolescents with correct and appropriate information within culturally acceptable norms. This approach contributes to broader geographical coverage, removing the gaps related to the limited number of school and students participating in the SE pilots. At this stage, about 10% of the schools are included in the pilots for the introduction of HLSE.

These innovative technologies have a complementary character but cannot replace school-based SE completely. These types of platforms might contribute (to a lesser extent) to the development of life-skills, where interactive and participatory methods in education have been proved to be more effective.

Youth-Friendly SRH Services

Tajikistan has an established network of YFHS across the entire country, however, they are only located in the urban areas, meaning rural adolescents and youth might not always benefit, leading to increased inequalities.

The demand for SRH services remains low. In order to increase the uptake of available services, more research is needed to address how effective the existing services are at addressing adolescent health needs, and what the main obstacles are for clients.

However, the newly approved National Strategy and Program for Reproductive Health (2019), with the main aim of improving access to the modern contraceptive methods for men and women of reproductive age, is also expected to contribute positively to the utilisation of YFHS.

Limitations of the findings

This is an exploratory study, and the author strived to consult the widest variety of sources to reflect a full picture of current developments around SE in Tajikistan. Unfortunately, due to the outbreak of COVID-19 in May 2020, the researcher could not recruit some of the potential KIs, such as a YFHS representative, and a teacher from a pilot site where SE is being implemented.

Also, despite a repeated requests to provide final versions of teaching materials for 10-11th grade students, including training manuals for teachers, the author failed to receive them. The assessment of content was conducted based on the latest available drafts, as provided by the KI. However, the drafts provided did include all the latest updates, which were approved by the Ministry of Education.

Conclusions

The analysis and findings of this thesis reveal that the SE program in Tajikistan has just started its spread and still is in the pilot phase. Comparing with SE programs in other countries in WHO European region, the comprehensiveness of the content is still low, although it is gradually improving. In the last four years, 10% (320 schools) of the secondary schools have piloted HLSE, compared with zero schools in 2016. At this point, the program is available only for older adolescents (15-17-years-old).

A fully fledged CSE program is not yet fully realised, but the basis has been established. In the last 10-12 years, Tajikistan has made significant progress in the area of SE. Considering the short amount of time since the introduction of SE , the developments show positive dynamics, although they tend to progress slowly. However, for a country with such a prevailing cultural climate, traditional outlook, and challenging historical and socio-economic background, these first steps are significant.

Although the term *sexuality education* has yet to be widely adopted in Tajikistan, selected topics related to SE, as defined by the WHO Standards, have gradually been included in HLSE. In reality though, HLSE is still not compulsory and remains an extracurricular subject. In practice, this means that schools are not required to provide it, and educators are not obliged to be trained in this subject. However, HLSE, including age-appropriate SE topics, can be taught in school, but outside the obligatory program, with the decision resting with the teacher. SE is also possible outside of schools provided that the training is age-appropriate, within culturally accepted norms and facilitated by trained personnel.

Despite the non-compulsory status of SE, the findings of this thesis show that ongoing advocacy, introduction and quality improvements attempts have all taken place in parallel, with international development organisations playing a significant role.

The main players, such as UNFPA, UNESCO, WHO, IPPF provide technical and financial assistance and support government agencies with advocacy, policy development, curriculum update, introduction of HLSE in the pilots, and the training of trainers.

As a result, the need for SRH education in the context of rising rates of HIV and STIs, high numbers of early marriages and teenage pregnancies in combination with low health literacy among adolescents, has been recognised. HLSE, including SE has, to some extent, been prioritised and addressed in a number of national strategies and programs, especially in the most recently approved strategies related to ASRH, where this component is clearly stated. SE policy language in existing but earlier approved documents is not always clearly elaborated, allowing room for interpretation. The government has improved the national legislative framework allowing adolescents access to SRH services and information. The national RH strategy and program are aligned with Target 3.7 of the Sustainable Development Goals, relating to universal access to sexual and reproductive health-care services.

From the above, the conclusion can be drawn, that the collaboration between the government and development organisations has resulted in the foundation of a system of connected elements required for an effective CSE program with the potential for further gradual adoption and implementation: an enabling environment, curriculum content, appropriate teacher training, contextualised delivery and support of YFHS.

Nevertheless, an analysis of the findings has also identified gaps in the current approach to SE, as well as barriers, which reduce effectiveness and prevent the scaling up of the program.

Firstly, the current SE program is focused on disease prevention and the protection of RH, with the aim of having a healthy family. Premarital adolescent sexuality is not forbidden but is hardly addressed and remains in the shadow of the main focus. Secondly, topics such as sexual diversity and sexual rights, are not discussed in the current curriculum. Thirdly, the current SE program is only targeted at older adolescents and youth.

In addition, cultural and religious opposition to SE is persistent and widespread. It affects decision-making, policy development, the comprehensiveness of the content, and acceptance of SE in general.

To continue the funding of SE programs is currently the biggest challenge. Sustainability has yet to be achieved, as existing activities in the area of SE are only possible with the financial support of international donors, which jeopardises further adaptation and the future of SE programs if external funding end.

Recommendations

After studying the literature regarding challenges in SE implementation and the possible ways to overcome them (51), (52), the WHO Action Plan for SRH towards sustainable development 2030 (53), and UNESCO Technical Guidance on SE (10), evidence-based information could be gathered to make recommendations in the context of Tajikistan. The following recommendations are for the national and international stakeholders, involved in advocacy, policy-development, and the introduction and implementation of the SE program in Tajikistan:

1) Ongoing advocacy for changing the status of SE to a compulsory subject must remain on the development agenda of international partners. Local civil society organisations, including youth organisations, should intensify advocacy as well, including explanatory work with communities, parental and religious organisations in order to reduce opposition to SE.

2) As part of the advocacy measures, involve both representatives of national decision-making agencies and representatives from the pilot sites in the regional conferences dedicated to ASRH and SE. Knowledge exchange and the experiences of other countries could be beneficial when elaborating national SE program strategies.
3) In the current pilot sites, establish a monitoring system to measure the transformation of students' knowledge, perception and attitudes related to SRH. Evaluation of gathered data will be instrumental in evidence-based decision-making and will contribute to advocacy efforts for program scaling-up.
4) Investigate existing possibilities for the early enrolment of students into SE programs. Review/use deliverables (e.g. teaching materials) from previous SE initiatives targeted at younger adolescents (10-15 years); assess opportunities for inclusion this age group in the current pilot projects and its monitoring.
5) Investigate and establish technologies for the distance training of trainers. In a country with poor infrastructure like Tajikistan, it can help to organise trainings during the entire year. In addition, introduce a moderated national online platform, where teachers can share best practises, exchange knowledge and needs, or ask for assistance with SE questions. A reward system for teachers, based on performance or innovative approaches to SE or use of this platform, could be a motivating factor. A (semi-annual) news brief about regional or national developments in SE could be of additional value. Sustainability should be taken into consideration when investigating this option.
6) Conduct a fiscal space analysis to optimise available funding to ensure a gradual, sustainable transition of the SE program (healthy lifestyle) to local ownership.
7) Conduct an analysis on how the current content of SE aligns with the WHO standards for SE in Europe, as well as how in-depth or comprehensively the topics recommended by the WHO have been covered. This is one of the short-term recommended interventions to reveal gaps and highlight ways of improvement.
8) If the extracurricular status of HLSE remains, integrated delivery of SE with other compulsory school subjects is recommended. Some of the neglected topics, such as development during adolescence, gender or sexuality can gradually be integrated into other school programs, such as anatomy, social studies or family ethics (or an established variant of these subjects). Benefits: connection of SE to different social and private roles of individuals; a broad range of topics; less dependency on the teacher to decide what to discuss during extracurricular hours. An important condition: training of educators on these additional topics and an updated curriculum. The integrated delivery will drive progress towards quality and comprehensive sexuality education.

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ANNEXES

Annex 1. Clearance Letter from Ethical Committee

KIT Royal Tropical Institute

RESEARCH ETHICS COMMITTEE

Contact: Meta Willems (secretary REC)
Telephone +31 (0)20 568 8514
m.willems@kit.nl

Amsterdam, 14 April 2020

Subject Decision Research Ethics Committee regarding a study on "Sexuality Program for adolescents: needs, components and current developments in the Republic of Tajikistan, Central Asia (S-117)"

Dear Natascha Andreeva,

The Research Ethics Committee (REC) of the Royal Tropical Institute has reviewed your application for a waiver for the study "Sexuality Program for adolescents: needs, components and current developments in the Republic of Tajikistan, Central Asia (S-117)", that was originally submitted on March 12, 2020 and resubmitted on April 10, 2020.

Your proposal which involves interviews by Skype with 4-6 stakeholders working on sexuality education in Tajikistan either as advocates, policy developers or implementers, is exempted from a full review, based on the following reasons:

a. the participants will be involved in their professional capacity only; the issues to be covered in the topic list cover information related to the duties of the respondents and information in the public domain; questions related to any personal questions are not included;
b. the participants will be asked informed consent before the data collection to make sure voluntary and informed participation is taking place and the participant is requested to participate and can decide to decline or withdraw participation at any moment during the process without any effect on reputation, or other consequences;
c. participating in this study does not foresee any physical, psychological and/or socio-economical risk or discomfort;
d. all information will be derived, processed, stored and published anonymously;

The Committee grants this waiver provided that you inform the KIT project officer responsible for GDPR for GDPR monitoring purposes.

The Committee requests you to inform the REC if substantive changes to the protocol are made, important changes to the research team take place or researchers are added to the research team.

The Netherlands
Fax +31 (0)20 568 8444

Moreover, the Committee requests you to send the final report of the research containing

a summary of the study's findings and conclusions to the Committee, for research monitoring purposes of the REC.

Please note that in case the final report is not submitted to the REC, or GDPR measurements are not taken care of sufficiently, this may have consequences for review of your next research proposal.

Wishing you success with the research,

Pam Baatsen
Chair of the KIT REC

Annex 2. Topic Guide for the Key Informants Interview

Interview with Key Informant, Topic Guide

CODE:
Ask informed consent from every individual participating in interviews
DRAFT FOR DATA RECORDING SHEET:
DATE ……. *TIME ……..……*
ORGANIZATION ……
DURATION ……
General comments ……

QUESTIONS	*SUB-QUESTIONS*
How long has your organization (YO) been involved in sexuality education (SE)? What has been the main focus?	*Global involvement, achievements* *Any regional involvement (Central Asia)?*
What are the main guidance documents for SE YO is using?	
Does YO collaborate with any (International) organization in this?	*Areas of collaboration, geography*
Since when has YO been involved in SE in Tajikistan (TJ) particularly?	*What is the main focus?* *What type of collaboration with the government of TJ?*
How you would define the progress in SE in TJ so far?	
What is the current SE agenda of YO in TJ?	*Geography, coverage, part of the global (European) initiatives or based on the country needs, financing of interventions in general.*
What are the age groups YO is focusing on?	
How does YO address the sexual and reproductive health needs of adolescents?	*What are the main needs? Based on the needs assessment? Or any other research/requests?* *Which components of the "Standards for Sexuality education in Europe" are (intended to be) covered?* *Geography*
Does YO collaborate with local partners/stakeholders?	*If government (advocacy), what levels, Ministries, etc.* *If field activities, which NGOs or others (schools, health facilities)*
What are the interventions of YO, duration of the activities	*If advocacy, policy development assistance, what is the timeline for the finalization and endorsement* *If activities, timeline, multi-year approach yes/no, any follow-up activities, evaluation, sustainability, accountability*
What are the main challenges YO have been facing in implementing SE agenda in TJ?	*Cultural barriers?* *Health Illiteracy?* *System?* *Financing?* *Priorities?*

What is the acceptance of interventions for the key groups/adolescents?	*Feedback from adolescents, health workers, school administrations, teachers?* *Experience adolescents, health workers* *Perception adolescents, health workers*
What is the SE agenda of YO for TJ in the near future?	*Perspectives* *Challenges*

Annex 3. Informed Consent Letter for the Key Informants

Informed consent Key Informants

Hello, my name is Natalia Andreeva, and I am a student at KIT Royal Tropical Institute, The Netherlands. I would like to better understand the Sexuality Education Program for adolescents: needs, components and current developments in Tajikistan.

I hope that received information will help to understand the role of international organisations, NGOs and societies in introducing components of comprehensive sexuality education for adolescents in Tajikistan, and to identify its opportunities and potential effects on health and development of the entire population in Tajikistan. The findings of this study will be used for the thesis (writing and defence) to complete the International Master Program in Public Health (summer 2020).

Procedures including confidentiality
If you agree, I would like to interview you about components of sexuality education your organisation is involved in as well as about experiences, progress and perceptions of sexuality education in Tajikistan.

The interview will take place via Skype in a private session where nobody can hear us and will last about 30-40 minutes at the in agreement chosen day and time, which will suit you.

To make sure that we do not forget or change what you are saying, with your permissioon, I will record the answers you give. Your name will not be recorded or written down, only the name of the organisation will be noted. Notes will be kept in a locked place. I will be the only one with access to the notes. Access to the computer and the working file will be protected with a password. Access to my e-mail has two-factor authentication as well.

In case of publication, the findings will be attributed to the background information in general and not to your particular area. Tape recordings will be destroyed six months after completion of the study scheduled for September 2020.

Risk, discomforts and right to withdraw
You are free to refuse to answer any question for any reason. Refusing to take part or withdrawing during the interview will not have any negative consequences. Your decision to do so will be not communicated to anybody else.

Benefits
This study will not help you directly, but the results will help to improve the sexuality education program.

Sharing the results
After completing the master program, the thesis will be available (in 2021) through the freely accessible Bibliotheca Alexandrina. You can use the link below https://bibalex.org/baifa/en/resources/search/dtp=thesis_-_dissertation/org=kit%20-%20royal%20tropical%20institute

Period of time to which the consent applies
The consent will be valid from the day it is has been signed by the participant until the end of the study, scheduled for September 2020.

Conflict of interest:
I declare no conflict of interest.

Consent and contact
Do you have any questions that you would like to ask?
Is there anything you would like me to explain again, or elaborate on?

Repeat: If you do not want to take part in this interview, you can refuse to do so, you can refuse to answer any questions and to stop the interview at any times. You will not be penalised in any way if you refuse to participate.
Do you agree to participate in the interview?

CERTIFICATE OF CONSENT: TO BE SIGNED BY THE RESPONDENT GIVING CONSENT:

Agreement respondent

The purpose of the interview was explained to me, and I agree to participate and understand that I can ask further questions, can refuse to answer any questions and stop the interview at any time.

_____

Signed Date

If you have any questions or want to file a complaint about the study, you may contact:

Contact information organization	Contact for Ethics Committee
KIT Royal Tropical Institute, The Netherlands	
Course administration	rec@kit.nl
course@kit.nl	