2021 Global CSE Survey Findings

Youth Coalition for Sexual and Reproductive Rights
International Youth Alliance for Family Planning Canada

youth coalition

INTERNATIONAL YOUTH ALLIANCE FOR FAMILY PLANNING CANADA

List of Acronyms

2SLGBTQQIA+
Two-Spirited, lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and other sexually and gender diverse people.
IYAFP Canada
Canadian Chapter of the International Youth Alliance for Family Planning
CSE
Comprehensive Sexuality Education
FGM/C
Female Genital Mutilation/Cutting
GBV
Gender-Based Violence
HIV
Human Immunodeficiency Virus
ICPD
International Conference on Population and Development
NGO
Non-governmental Organization
SRH
Sexual and Reproductive Health
SRHR
Sexual and Reproductive Health and Rights
STIs
Sexually Transmitted Infections
YCSRR
Youth Coalition for Sexual and Reproductive Rights
WHO
World Health Organization

Introduction

The Youth Coalition for Sexual and Reproductive Rights (YCSRR) and the Canadian Chapter of the International Youth Alliance for Family Planning (IYAFP Canada) have come together to develop this global report, in collaboration with several youth-led and youth-serving organizations, to highlight some key concerns and recommendations for the implementation of Comprehensive Sexuality Education (CSE) for young people.

The YCSRR is an international organization of young people based in Ottawa, committed to promoting youth sexual and reproductive rights. YCSRR works to ensure the meaningful participation of all young people in decision-making that affects their lives through advocacy, knowledge generation, information sharing, partnership building and the capacity strengthening of young activists. IYAFP Canada is an alliance of young people, organizations, and global communities with a mission to support comprehensive and equitable reproductive health care. IYAFP Canada is a for-youth, by-youth organization advancing the state of sexual and reproductive health, access, rights, and justice in what is currently known as Canada.

This report reflects on three key aspects: (i) the current status and history of CSE; (ii) global youth perspectives on comprehensive sexuality education and related resources; (iii) and calls to action to improve CSE, based on our findings. One of our motivations in creating this report is our desire to showcase the emerging trends and barriers in accessing CSE across the globe and to amplify the voices of young people impacted by CSE in a more proactive and co-leading role to ensure meaningful youth engagement.

Acknowledgements

This report would not be possible without the support and guidance from various youth-led and youth-serving organizations. This section outlines individuals and organizations committed to bringing further awareness to young people's access to sexual and reproductive health services across the globe. We encourage readers to engage, connect,and align themselves with their works.

We wish to acknowledge YCSRR and IYAFP Canada for their tireless work on developing the global survey and subsequentvreport. We want to thank YCSRR staff Eunice Garcia, Maria Leon, and Ryan Yevcak, and member Charlie Acosta, as well as IYAFP Canada members Erika Dupuis, Donna Ng, Harsimran Grewal, Holly Foxall, Janie Moyen, Jasmine Ali-Gami, Carole-Ann Filiatreault, Stefania Wisofschi, and Vesela Ivanova.

As well, we would like to thank and highlight the following organizations for their support: African Young Positives, Agora AC, Asia Safe Abortion Network, CSIH Mentor-Net, Global Early Adolescent Study at Johns Hopkins, Guttmacher Institute, Human Rights Campaign Brasil, IYAFP Albania, IYAFP Burkina Faso, IYAFP Burundi, IYAFP DRC, IYAFP Ethiopia, IYAFP Rwanda, IYAFP Sierra Leone, IYAFP South Africa, Marijan, Medical Students for Choice, Network of YKP in Ghana, Philippine Safe Abortion Advocacy Network, Projet Jeune Leader, Restless Development USA, Sexuality Education Kerala, Taarifa ni Maisha, The Young Canadians Roundtable on Health, ThriveHire, Torchlight Collective, Y Labs Global, Y Peer Nepal, Youth Advocacy Network Sri Lanka, Zamara Foundation, and the Women's Global Network for Reproductive Rights.

YCSRR and International Youth Alliance for Family Planning Canada recognize that this report would not have been possible without the organizations as mentioned above. Both organizations would like to offer their sincerest gratitude for their continuous support of this report, for their enthusiasm and direction.

This report is dedicated to those who participated in the report's development, to the service providers and organizations committed to reducing social, health, and economic harms related to sexual and reproductive health care, and in remembrance of those who are no longer with us.

BACKGROUND

Comprehensive Sexuality Education (CSE) is defined as:

"A curriculum-based process of teaching and learning about the 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 realize 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."

(UNESCO Technical Guidance on Sexuality Education, 2018)

The 1994 International Conference on Population and Development (ICPD) in Cairo underscored the importance of promoting young people's well-being through age-appropriate and empowering sexuality education in school and at the community level (United Nations, 1995). A critical need for accurate and accessible sexual and reproductive health information was identified. Since 1994, similar international agreements and calls for global collaboration reaffirmed the importance of comprehensive sexuality education on young people's sexual and reproductive health and the achievement of gender equality and recognition of human rights (Leung et al., 2019). Nonetheless, despite investments in CSE, grave trends are observed due to ongoing challenges to implementation and organized opposition fueled by misconceptions surrounding CSE (Rutgers, 2019). International prioritization of CSE was reinforced in 2019 through the Nairobi Summit ICPD+25 Statement, denoting its commitment to expanding:

"Access for all adolescents and youth, especially girls, to comprehensive and age-responsive information, education and adolescent-friendly comprehensive quality and timely services to be able to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexuality transmitted infectionc, including HIV/AIDS, to facilitate a safe transition into adulthood."

(UNFPA, 2019)

Despite the mandated emphasis on CSE, sexuality education is often unevenly implemented and remains unavailable in many countries worldwide. A review of sexuality education in 28 Asian-Pacific countries found that few referenced sexuality education in their education strategies (UNESCO, 2012). Regionally and nationally, CSE opposition is reflected in the misinformation and fear of any teachings that challenge an abstinence-only education. In countries that have implemented CSE programmes, there remain gaps in the topics covered in sexuality education curricula. Existing barriers such as social opposition and resource constraints prevent young people from receiving the

quality of education they need to enable them to protect their sexual reproductive health. For example, community and parental resistance to CSE is prevalent in some countries and can roll back the progress of implementing CSE policies. In Uganda, comprehensive sexuality education beyond abstinence-only education was banned in 2016 in response to public resistance (UNESCO, 2019). Such resistance to CSE can be impacted by misconceptions about CSE. The ban was later repealed in response to calls made by civil society organizations. In Latin America, similar resistance is propagated by religious and conservative groups (Leung et al., 2019). While young people's demand for their right to CSE increases, evidence reveals that gaps exist, in particular surrounding content covering access to services, STIs and abortion, with few programs meeting the criteria outlined in the International Technical Guidance on Sexuality Education (Haberland, 2014; UNFPA, 2016; UNFPA, 2012; UNFPA, 2018).

Resource constraints also prevent young people from accessing quality CSE. For example, teachers may not be adequately trained to provide CSE. In Ghana, Guatemala and Peru, about 75% of teachers reported receiving inadequate lesson plans and activities (Keogh et al., 2018). Young people from these countries also revealed that their views were not sufficiently considered when designing curricula or CSE guidelines (Keogh et al., 2018). Teachers' personal views may also impact the way they deliver content to students. Strengthening teachers' skills and confidence in CSE delivery is critical to improving CSE in schools.

Unsurprisingly, implementation lags behind policy as implementation is plagued by shifting governmental priorities, religious and conservative pressures, inconsistencies in curricula and integration across relevant ministries, and stigma surrounding young people's sexuality (Haberland, 2014). The intergovernmental commitments call for "access for all;" however, a 14-country review found that few programs were engaging out-of-school youth (UNFPA, 2016). There remains tension between the targeted advocacy toward school-based CSE to reach the greatest number of young people and including young people from specific left-behind populations, including young people with disabilities, young Indigenous people, members who identify as LGBTQIA+, young people in detention, and those who engage in transactional sex (UNFPA, 2020).

Community-based CSE demands tailored delivery models that are by definition more challenging to implement at scale. Effective CSE is inclusive and contextualized to the specific needs of young people. Young people often seek SRH information from peers or internet sources, but evidence demonstrates that CSE is most effective when delivered by trained and trusted individuals (UNESCO, 2015). Community and out-of-school programs complement existing CSE mechanisms and include community-based components to support young people (UNESCO, 2015). This may include trained peer networks or leveraging existing and youth-friendly structures to deliver CSE. The International Technical and Programmatic Guidance on Out-of-School Comprehensive Sexuality Education responds to the urgent need to meet the needs of the hardest-to-reach young people, who often face increased risks of sexual and gender-based violence, stigma, and adverse health outcomes (UNFPA, 2020).

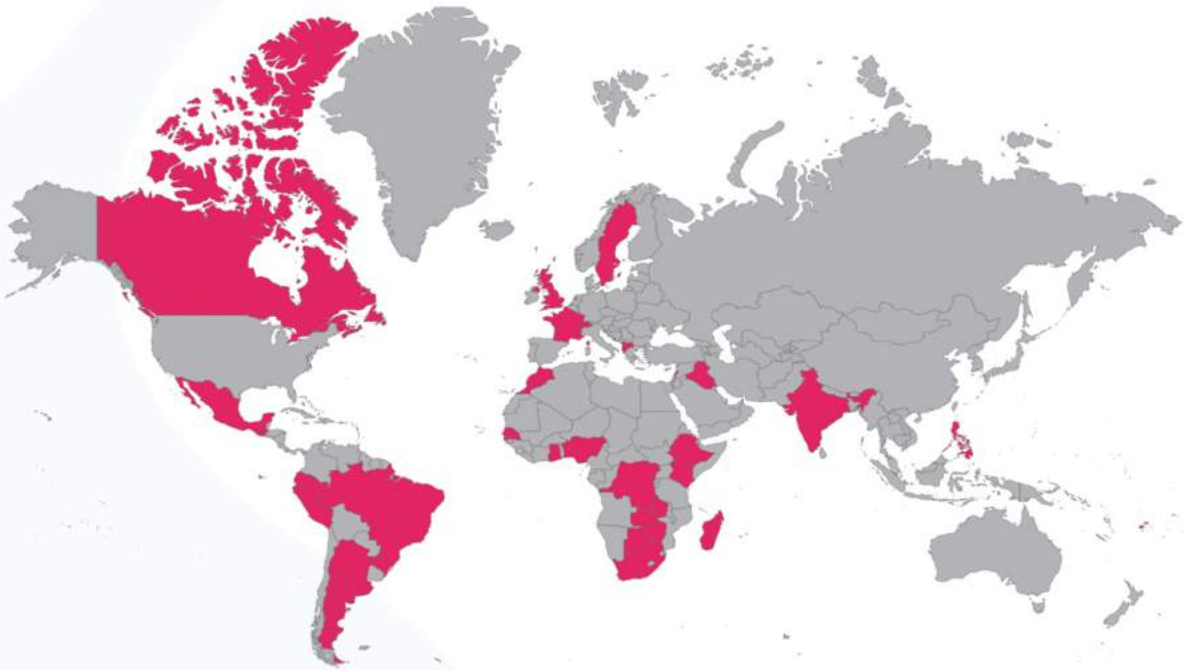
DEMOGRAPHICS

In total, **117** young people across the globe offered their thoughts regarding CSE. The #YouthForCSE Survey consisted of 34 open and close-ended questions. All surveyed participants provided their informed and written consent for their findings and quotations to be shared. All responses, findings, and direct quotations have been anonymized.

REGIONAL
Respondents reported residing in the following regions: Africa (44), North America (16), Latin America (28), Asia (12), Europe (15) and the Oceania region (two). The survey captured responses from 32 countries (in alphabetical order): Albania, Argentina, Benin, Botswana, Brazil, Canada, the Democratic Republic of the Congo (DRC), Ecuador, Ethiopia, Fiji, France, Ghana, Guatemala, India, Iraq, Kenya, Kiribati, Lebanon, Madagascar, Mexico, Morocco, Nigeria, North Macedonia, Peru, Philippines, Senegal, South Africa, Sweden, Switzerland, United Kingdom, Zambia, and Zimbabwe.

As a result of the geographic considerations, and given the purpose of the report, respondents were divided into the following larger geographic regions: Africa, South America (inclusive of Mexico), Asia and Oceania, as well as North America and Europe. A breakdown of each country and its respective region is provided below.

Africa: Benin, Botswana, DRC, Ethiopia, Ghana, Kenya, Madagascar, Morocco, Nigeria, Senegal, South Africa, Zambia, and Zimbabwe.
Asia and Oceania: Fiji, India, Iraq, Kiribati, Lebanon, and the Philippines.
North America and Europe: Albania, Canada, France, North Macedonia, Sweden, Switzerland, and the United Kingdom.
Latin America: Argentina, Brazil, Ecuador, Guatemala, Mexico, and Peru.



It is important to note that the survey did not receive any responses from the Caribbean region. This is one of the limitations of the survey. Additionally, we want to acknowledge and highlight that these groupings are not reflective of individual, regional, and country-specific experiences. In highlighting this consideration, we wish to be intentional in recognizing the participants' innate, socio-political, economic, and geographic differences. We encourage readers to keep this reflection in mind when reviewing the report.

Aside from regional and geographic-based data, youth survey participants were also provided space to self-identify their age, gender identity, race, and disability.

AGE

As seen in Figure 1, a majority of respondents identified between the ages of 20 to 24 (41%). This was followed by ages 25 to 29 (31%), 30 and over (11%), 16 to 19 (0.7%), and finally, 15 and under (0.17%).

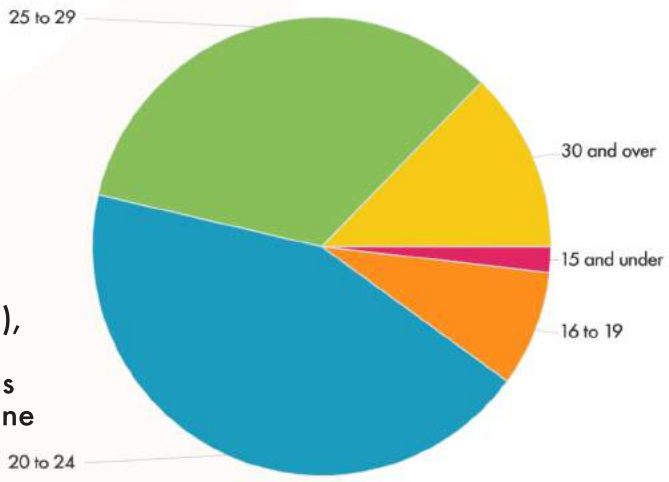


FIGURE 1

GENDER

Based on survey responses, 70 participants identified as women (including trans women), 38 identified as men (including trans men), six identified as non-binary, one identified as genderqueer, one identified as other, and one preferred not to identify.

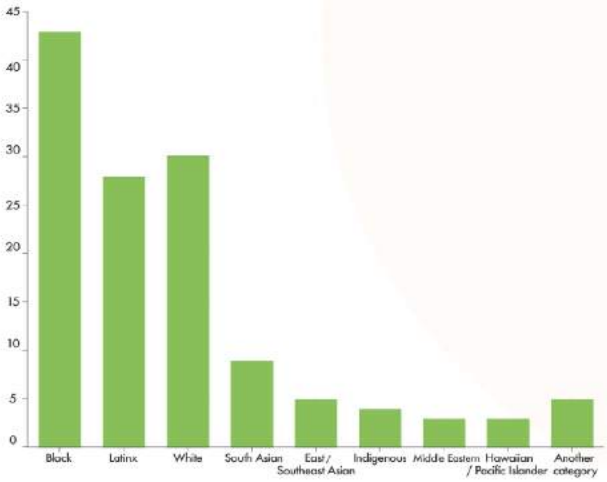


FIGURE 2

RACE

As seen in Figure 2, out of the the 117 survey responses, most respondents identified as Black (36%), followed by Latinx/Hispanic (28%), White (18%), South Asian (0.7%), East/Southeast Asian (0.4%), Indigenous (0.3%), Middle Eastern (0.2%) and Hawaiian / Pacific Islander (0.2%). Five respondents (0.4%) identified as another racial category or a category not mentioned.

DISABILITY

Among the survey respondents, six self-identified as living with a disability, while 110 reported no disability and one preferred not to say.

> **"People always think that sex ed is more on the intercourse part when it really is more than that. It's the notion of consent, respect, and control. [Youth] experiment on their own because they were never given safe spaces to learn about it.**
> - Youth Participant, Philippines

FINDINGS

This section will focus on highlighting findings from the global #YouthForCSE questionnaire.The survey and its subsequent sections are divided into four major domains: 1) sexuality education and health service access, 2) CSE in schools and communities, 3) experiences in learning CSE, and 4) implications for CSE for the future.

UTILIZATION OF SEXUAL HEALTH SERVICES

78% of survey participants identified as having utilized sexual health services in the past two years, with 17% identifying no use of sexual health services and 0.01% who preferred not to say.

Out of the participants who had utilized sexual health services, 16% were youth from Asiaand Oceania, 40% were from Africa, 17% from Europe or North America, and 24% were from Latin America. Regionally, 100% of Asian and Oceanic youth reported accessing of sexual health services in the past two years, compared to 81% for African youth, 78% for Latin American youth, and 66% for European and North American Youth.

100% of gender diverse, queer, and trans youth reported using sexual health services in the past two years. Similarly, 100% of youth who identify as having a disability also reported utilizing sexual health services in the past two years.

BARRIERS TO ACCESS

Survey respondents were asked to name barriers to accessing sexual health services in their area. In all regions, 'stigma, privacy and confidentiality' was the most frequently selected option, with the exception of Africa, where 'stigma, privacy and confidentiality' were tied with barriers associated with the 'cost of services' as the most popular options. Over 65% of all respondents indicated that stigma, privacy, and confidentiality was a barrier. 100% of youth that identified as having a disability considered stigma, privacy and confidentiality as barriers. Limited sexual health knowledge' was cited as the second most common barrier to accessing sexual health resources.

Over 65%

of survey respondents identified cost of services, as well as stigma, privacy, and confidentiality as the biggest barrier to accessing sexual health services

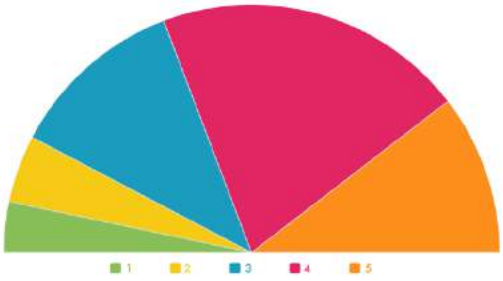


FIGURE 3

SEXUAL HEALTH SERVICES EXPERIENCE

As seen in Figure 3, the survey also sought respondents' rankings and self-reflection for their own experiences receiving sexual health services, with (1) being the worst and (5) being the best. Six participants ranked their experience at (1), eight ranked their experience as (2), 21 ranked their experience at (3), 37 at (4), and 19 as (5).

The most common ranking (i.e. the response that appeared most often) was determined for key groups. Queer, trans, andgender diverse youth most often rated their experience as neutral (3). Moreover, young people with disabilities most often reported the worst experiences, rating their service delivery at (1).

When examining regional differences in ratings, those living in Asia and Oceania ranked their experience a 4 out of 5, those based in Africa also ranked theirs a 4 out of 5, while youth in Latin America ranked theirs a 3 out of 5, and finally, those based in Europe and North America ranked their experience as a 2 out of 5.

IMPACT OF COVID-19

When asked to rank their level of difficulty accessing sexual health care during the COVID-19 pandemic on a scale of 1 to 5 (with 1 being very difficult), the most significant number of respondents reported their level of difficulty at 2. 13 participants reported the greatest level of difficulty (1) in accessing sexual health care. Additionally, 25 respondents reported a level of 3, while 13 reported a level of 4. Lastly, 19 participants reported the lowest level of difficulty by choosing a difficulty level of 5.

As seen in Figure 4, among youth based in Asia and Oceania, 26% reported a level 1 difficulty accessing sexual health services. An additional 26% of youth in this region reported a level of 3. Moreover, 34% of African youth ranked their difficulty in accessing sexual health services at 2. In Europe and North America, 25% reported a difficulty level of 4. Among Latin American youth, the most common response (28%) was a level 3 difficulty accessing sexual health services.

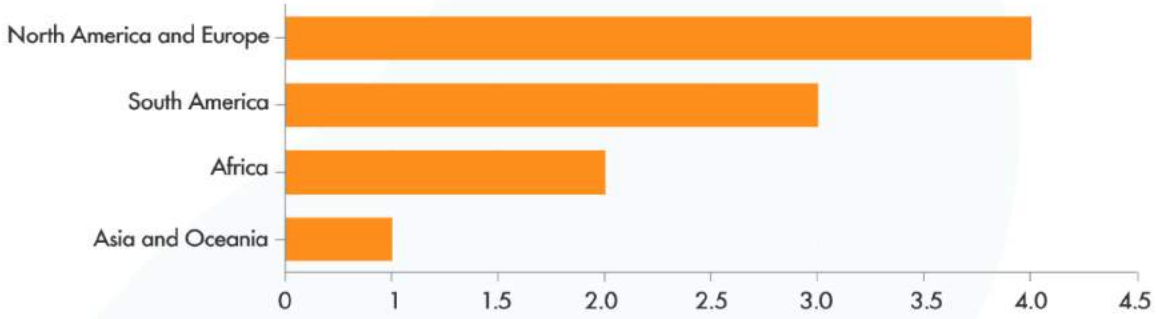


FIGURE 4

Gender diverse, queer, and trans youth predominantly reported a difficulty level of 2. Lastly, the most popular responses for youth with disabilities were levels 1 and 3.

> **"Currently in my area because of the amount of COVID-19 tests that they are processing in the labs my local sexual health centre is not able to process STI swabs, urine or blood tests unless the individual is pregnant. While this doesn't impact me directly at this moment, it could if I needed to have a check up and impacts many others.** - Youth Participant, Canada

> **"COVID-19 [has] had a financial impact on me and I don't have the means anymore to access sexual health services.** - Youth Participant, Madagascar

INTRODUCTION TO SEXUALITY EDUCATION

Across all surveys and demographics, the predominant age at which young people were introduced to sexuality education ranged between the ages of nine and ten. However, a significant number of participants shared that they did not receive sexuality education in school. Of those who did receive sexuality education, it was reported that they started learning about sexuality education between grades four and five.

This question was followed by asking respondents to reflect on the age they wished to have received sexuality education compared to the actual age they were first introduced. Across all surveys, young people repeatedly voiced wanting to learn sexuality education at a much earlier age compared to their actual introduction.

MATERIAL COVERED IN SEXUALITY EDUCATION

Participants reported the topics covered during their introduction to sexuality education. Based on the geographic region, 53% of respondents in Asia and Oceania reported not receiving any sexuality education. 36% of those residing in Africa most commonly reported learning introductory topics on safer sex practices, alongside 50% of those residing in Europe and North America as well as 32% in Latin America.

Queer, trans, and gender diverse participants reported learning more about puberty and sexual intercourse during their sexuality education introduction, whereas those living with disability reported puberty and safer sex practices being learnt most frequently. To follow-up on questions asked about these introductory topics, participants were asked to share what topics were covered not just in their introduction, but also throughout their sexuality education experience.

Young people based within Asia and Oceania regions predominantly reported that they did not receive sexuality education. A majority of youth based in Africa reported learning about puberty, pregnancy, HIV and other sexually transmitted infections (STIs), and menstruation. European and North American youth reported learning of safer sex practices, sexual risk-taking, pregnancy, HIV and other STIs, as well as condoms and contraception use. Lastly, Latin American-based youth predominantly reported learning topics covering safer sex practices, pregnancy, HIV and other STIs, condom and contraception use, abstinence, and menstruation.

OVERALL EXPERIENCES WITH SEXUALITY EDUCATION IN SCHOOL

Young people also rated their experiences of school-based sexuality education on a scale between 1 (an abysmal experience) and 5 (a near-perfect experience). Of those who participated in school-based sexuality education, 40% of Asia and Oceania-based youth ranked their experiences at 1 out of 5. 33% of Europe and North American-based youth ranked their experience as a 2 out of 5. 38% of Africa-based youth ranked their experiences at 3. Finally, 42% of Latin American-based youth also rated their experience a 3 out of 5.

> **"Peer based education and online resources, especially in local languages are the [best] ways to find information. With peer education, conversations about various SRH issues are more comfortable as the educators are usually in the similar age group.**
> - Youth Participant, India

Queer, trans, and sexually diverse participants unanimously reported their in-school sexual education experiences as a 1 out of 5. A majority of youth who identify with a disability reported their experience at 2 out of 5.

OVERALL EXPERIENCES WITH OUT-OF-SCHOOL SEXUALITY EDUCATION

In contrast, we asked young people to rate their experiences with out-of-school sexual education (i.e., community-based, peer-based) on a scale between 1 (i.e., very poor) and 5 (a near-perfect experience). As seen in Figure 5, 35% of respondents rated their satisfaction at a 4. Satisfaction was ranked mostly highly amongst respondents in Africa, with 38% of respondents indicating a 5 rating. In both Asia and Oceania as well as Europe and North America, the majority of respondents at 40% and 37%, respectively, rated their satisfaction at a 4. Respondents in Latin America rated their satisfaction at the lowest level, with 33% of respondents indicating a level 1 rating.

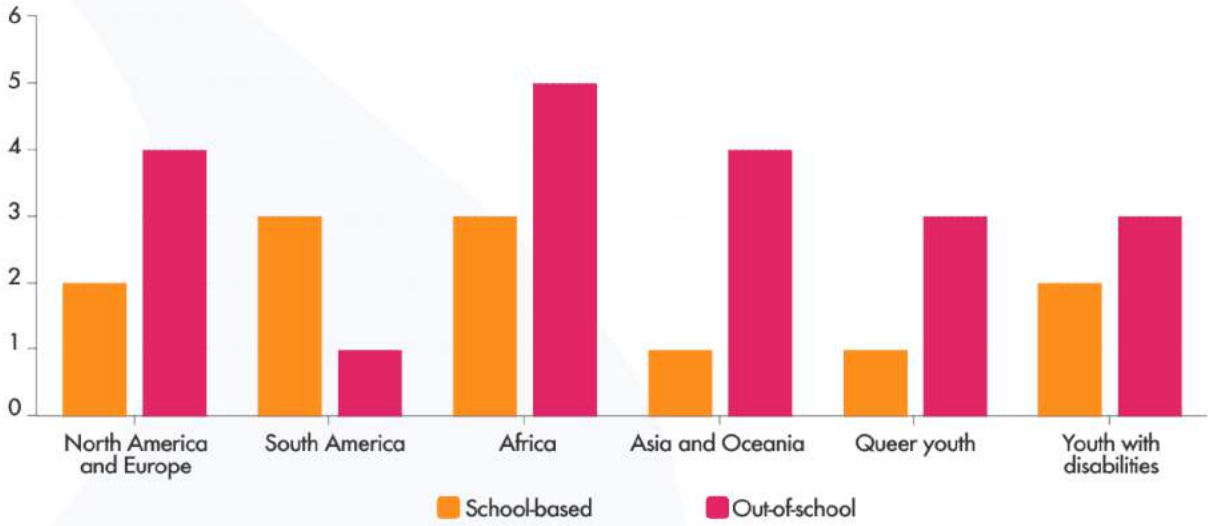


FIGURE 5

Amongst queer, trans, and gender diverse youth and youth identified as persons with a disability, respondents reported a 3 out of 5 satisfaction rating for their out-of-school sexuality education experience.

ACCESSING SEXUAL HEALTH INFORMATION AND SERVICES

When asked about access to sexuality education, 62% of youth in Europe and North America and 40% of youth from Asia and Oceania shared that they access information through their friends and peers. 27% of African-based youth reported receiving information from their family, and 25% of Latin America-based youth reported learning from friends and peers. Similarly, both queer, trans, and gender diverse youth, as well as youth who identified as a young person with disabilities, also reported receiving their information through peers and friends.

REGIONAL CONSIDERATIONS FOR SEXUALITY EDUCATION

Across all surveys, youth identified consent, destigmatization, awareness and knowledge, pleasure and sexuality, contraception, accessibility, quality of services and inclusion of gender identity as the most pressing sexuality education needs in their regions. Additionally, a significant number of young people expressed that all sexual health issues, within their respective regions are both pressing and significant.

80% of youth based in Asia and Oceania reported their most significant and pressing need in sexuality education as being an improvement in the quality of sexual health services as well as expansion and information on STI testing. 74% of Latin American-based youth identified improved STI testing, as well as inclusion of pleasure and sexuality within sexuality education as the most significant regional need. 60% of

European and North American youth reported the inclusion of pleasure and sexuality in sexuality education. Lastly, 11% of African youth reported discussions around early pregnancy and safer sex practices as their most pressing need in sexuality education.

REGIONAL CONSIDERATIONS FOR CSE

Overall, the most predominant response across all surveys concerning the most critical element to consider when implementing CSE in each respective region was the development of age-appropriate content (i.e., learning comprehensive sexuality education at earlier ages and prolonging sexuality education throughout young adulthood). Regionally, both European and North American youth, along with Asian and Oceanic youth, also ranked age-appropriate content as the most important consideration for implementation of CSE in their regions, with 55% and 53%, respectively. That being said, 50% of African youth and 33% of Latin American youth shared that establishing connections between communities and families is a primary element for implementing CSE.

THE CASE FOR CSE: FROM YOUTH, BY YOUTH

Young people were asked to provide their insights on why CSE is important to them and where they would like to CSE in ten years time. View their responses below.

> **"[CSE] is important! Sexuality occurs earlier and earlier in youth lives, and violence as well unfortunately. The sooner they are informed, the better.** - Youth Participant, France

> **"[I'd like to see CSE] overcome sexism, misogyny, and combat violence (whether of race, gender identity).** - Youth Participant, Brazil

> **"[Current sexual health education] should be a more holistic and non-stigmatized sex education. It should include not only reproductive health but also how to live sexuality, even if it is not heterosexual/cisgender /endosexual/allosexual.** - Youth Participant, Mexico

> **"My main takeaway is that noncis and nonhet people will still build spaces for these conversations even with no one to lead them. This is also influenced on how cisheteronormativity, cisheteropatriarchy, and hegemonic masculinity influences our view on our bodies and that there is little to no resistance on challenging these views because of lack of agency. Even noncis, nonhet communities build their own hierarchies that is built in the systems of oppression mentioned. Of course this is miseducation, but for a young 2SLGBTQQIA+ person, this is the only one we got.** - Youth Participant, Philippines

DISCUSSION

GEOGRAPHICAL DIFFERENCES

The #YouthForCSE campaign drew responses from over 117 youth across 32 countries. The highest number of respondents (18) resided in Madagascar, followed by respondents in Mexico (16), Benin (13), and Canada (ten). Based on survey responses, there is a need for additional voices from the Caribbean, Eastern Europe, South Asia, and the Middle East and North Africa. Compared to previously reported findings, there are significant implications for the four regions - Africa, Latin America, Asia and Oceania, as well as North America and Europe, and their implementation of CSE.

Youth were asked if they had accessed sexuality education resources or sexual health services in the past two years, and the majority of youth across all regions responded 'yes.' In Africa, 86% of youth had accessed resources in the past two years, while 79% of youth in Latin America had accessed resources during the same time. Respondents in North America and Europe reported the lowest rate (67%) of service and resource, while all respondents (100%) from Asia and Oceania had all accessed resources in the last two years. Due to high levels and uptake of sexual health services by all participants, it can be interpreted that the greater awareness of sexual health services can contribute to a higher demand for such services, leading to an increase in access and availability.

Subsequently, participants were then asked to rate their experience on a scale of 1 to 5 (1 = not satisfied, 5 = very satisfied). Youth in Africa and Asia and Oceania ranked their experiences the highest, at 4 out of 5. With high satisfaction of sexual health resources, as reported in Africa and Asia and Oceania, comes an increased demand for said services. Satisfaction of sexual health services is a significant component in young peoples' willingness to return and the continued utilization of services (Cassidy et al., 2018). In North America and Europe, youth reported the lowest level of satisfaction, 2 out of 5. Latin American youth reflected neutral satisfaction, ranking their experience as 3 out of 5. Across all regions, the most selected barrier to accessing sexuality education and resources was 'stigma, privacy, and confidentiality.' As noted in Nmadu, Mohamed, and Usman (2020), there is a significant need for making young people aware of their sexual and reproductive rights to strengthen their power and capacity to make informed decisions on their SRH-related care. With 'stigma, privacy, and confidentiality' being the primary barrier for most respondents, it is essential to engage, include, and co-develop services intended for young people with young people.

Despite reporting high SRH service seeking and satisfaction, the majority of respondents (53%) from Asia and Oceania noted that they did not receive sexuality education, with 40% selecting friends and peers as the primary sources of SRH information. This group also ranked their experience with school-based education poor, as 40% of respondents from Asia and Oceania rated their experience 1 out of 5. These findings suggest that despite the high demand for SRH services and resources, sexuality education remains inaccessible, especially concerning school-based approaches.

The uneven implementation of CSE, and its impact as showcased by regional statistics, cannot be understated. Reasons for the unequal distribution may be due, in part, to different modes of dissemination, for example, government and educational structures versus non-profit and non-governmental organizations. For example, most youth in Africa noted a high level of satisfaction in out-of-school sexuality education versus their Latin American counterparts, which reported a high level of satisfaction for in-school sexuality education. One of the greatest outcomes of the strong network of community-based organizations in Africa has been the collaboration of governments and NGO partners in promoting CSE through community-based programmes; however, CSE remains largely donor driven. While in Latin America, Health and Education ministers co-signed agreements mandating for national school-based CSE (UNESCO, 2015). This difference may be due, in part, to regional priorities and funding structures. Ultimately, high quality CSE services demand both government commitment and sustained funding to enable and facilitate the continued access to CSE.

Perspectives on the critical needs surrounding sexuality education varied across regions. An overwhelming 80% of youth in Asia and Oceania reported their most significant and pressing need as an improvement in the quality of sexual health services and the dissemination of information related to STI testing. Improved STI testing was also identified by 74% of youth in Latin America. Across all regions, the inclusion of topics covering consent, pleasure, and sexuality was also highlighted toward achieving empowering sexuality education. Finally, when asked to comment on CSE implementation in their region, youth in Europe, North America, Asia, and Oceania ranked age-appropriate content as the most crucial consideration. This strengthens participants' previously reported reflection that young people desire to learn sexuality education much earlier in adolescence in comparison to their first introduction.

Meanwhile, youth in Africa and South America shared that establishing connections between communities and families are the most critical elements for implementing CSE. The need to incorporate both community and family-centric responses in the implementation of CSE and sexual health services is a critical component to capture the nuances of identity, social norms, and social determinants, which can improve access and service coordination for young people (Cordova Pozo et al., 2015; Nmadu, Mohamed & Usman, 2020).

Our survey revealed relevant commonalities and differences for youth in different areas of the world. While many of the barriers and concerns about sexuality education were universal, the appropriate strategies needed to address these may differ across regions. In Africa and Latin America, respondents indicated a preference for family and community-focused approaches as fundamental to improving CSE. In contrast, respondents from Europe, North America and Asia and Oceania noted significant gaps in the success of in-school sexuality education. In the majority of regions, with the exception of South America, youth ranked their experience with out-of-school sexuality education higher than school-based sexuality education. Our data indicates that while there is much work to be done in many areas of expanding access to CSE, improving coordinated and integrated approaches across all sectors, whether quality improvement in schools or expansion of services and resources at the community level, is an important issue across all regions.

GENDER-BASED DIFFERENCES

Of 117 respondents, 55% identified as women (including trans women), 32% identified as men (including trans men), 5% identified as non-binary, and 2% identified as genderqueer or other (one participant preferred not to identify, and one chose not to respond). With respect to utilization of SRH services, all surveyed youth who identified as queer, trans,

and gender diverse reported using sexual health services in the past two years, followed by men (87%), and lastly, women (75%). Despite the highest frequency of utilization, queer, trans, and gender diverse youth reported the lowest level of satisfaction with sexual health services. While queer, trans, and gender diverse youth encompass a small sample within the survey, respondents have emphasized the need for greater access, inclusion, and integration of 2SLGBTQQIA+ and gender diverse perspectives in the facilitationvand material of CSE. There was no significant difference between the experience ofvwomen compared to men. Queer, trans, and gender diverse youth-rated lower satisfaction with community-based sexuality education compared to in-class.

Women noted that sexuality education primarily focused on anatomy and pregnancy prevention and omitted discussions surrounding consent, intimacy, pleasure, healthy relationships, or 2SLGBTQQIA+ perspectives. While some men reported no gaps in their sexuality education, they did reference feeling uncomfortable asking questions in spaces where sexuality education was delivered (i.e., classrooms). Men respondents also referenced similar gaps as highlighted by women respondents. Trans, genderqueer, and non-binary youth identified omissions of topics covering sexual diversity, 2SLGBTQQIA+ sexual health, and consent. Learning about sexual health topics for all genders can help break down stigma and encourage empathy. For example, one respondent said they would have valued learning in school *"that masturbating for a girl is not a shame"* (Youth Participant, France).

These gender differences demonstrate the importance of capturing and engaging diversified perspectives and experiences in sexuality education. However, as previously noted, the inclusion of 2SLGBTQQIA+ perspectives in sexuality education alone will not combat the inequities and discrepancies faced by queer, trans, and gender diverse youth's satisfaction rates with sexuality education. Continued recognition of the realities of 2SLGBTQQIA+ youth, documentation of successes and barriers, omission of heteropatriarchal approaches to education, and sustained research will also complement and advance sexuality education for future generations.

CSE APPROACHES: IN-SCHOOL VERSUS OUT-OF-SCHOOL

Survey findings revealed that the majority of young people surveyed prefer out-of-school sexuality education compared to school-based CSE. This highlights the importance of complementing high-quality sexuality education in schools embedded out-of-school SRH programs for young people. Out-of-school sexuality education can be delivered through trusted facilitators, parents, peer educators (UNFPA, 2020). In addition, this approach provides flexible environments where learners with shared experiences or who belong to similar age groups can come together to share knowledge (UNESCO, 2018). For example, one respondent from Canada noted that their out-of-school sexuality education was *"more inclusive and talked about the LGBTQ+ perspective,"* while a participant from Mexico shared that out-of-school programs *"spoke clearly and without taboos on [sexual health]."*

Young people from Asia and Oceania, Europe and North America, and Africa also identified peer-based education as practical ways for CSE delivery. Participants reported receiving most of their sexuality education from friends, peers and family. Peer-based education can be an essential component of both out-of-school and school-based programs. Sexuality education may be delivered through various approaches such as one-to-one conversations, distribution of informative materials, and advocacy mobilization (UNESCO, 2018). Some respondents specified that peer-based education allowed them to have open conversations without shame,

highlighting the importance of providing sexuality education free of stigma or judgment. Additionally, respondents from Asia and Oceania also referenced the inclusion of external community-based educators in educational settings to implement programs.

Youth from North America and Europe, Latin America, and Africa also reported that prioritizing CSE in school curricula would be one of the best ways to implement CSE in schools. Nonetheless, while many countries have developed national CSE curricula, participants' responses reveal that their preference toward out-of-school CSE is largely due to the inadequacy of available school-based CSE at the local levels sustained by challenges in implementation and roll-out. These challenges include lack of prioritization in integrating CSE in lessons, insufficient local contextualization, and limited stakeholder engagement in curriculum development.

Youth from all regions also often expressed that additional training for teachers would be beneficial to improve their CSE provision. Such responses highlight the societal and operational barriers that hinder CSE implementation in schools. While youth expressed additional training for teachers, it would be helpful to look into the barriers that may prevent teachers from delivering comprehensive and accurate SRH information. For example, policies, guidelines and curricula dictate the SRH topics that teachers may discuss with students. These policies may also be influenced by cultural and community beliefs regarding sexuality education (UNESCO, 2019). Findings also recommend expanding support and training teachers. Teachers require training that allows them to rehearse key topics, build their capability, and develop their confidence as educators (UNESCO, 2019). According to the International Technical Guidance on Sexuality Education (2018), training should also help teachers distinguish their personal values from the needs of learners.

BARRIERS TO CSE & SRH ACCESS

Across all regions, 'stigma, privacy, and confidentiality' was identified as the greatest barrier to accessing CSE. Respondents indicated that there were taboos or stigma associated with talking about young people's sexual health and sexuality. For example, one participant expressed, *"...in Brazil, schools, especially public schools, and society itself has a very big taboo in relation to sex education"* (Youth Participant, Brazil). Another respondent indicated that *"young people have difficulty accessing services because of shame, lack of support and financial services"* (Youth Participant, Madagascar). When asked about where youth would like to see sexuality education in ten years, many respondentsexpressed that they would like CSE to be non-stigmatized and would like for there to be open discussions surrounding sexual health topics.

In Africa, the cost of services was a secondary barrier highlighted by young people. This may be further exacerbated by the financial impact that the COVID-19 pandemic has had on young people. For example, a participant expressed, *"COVID-19 has had a financial impact on me and I can no longer afford to access sexual health services"* (Youth Participant, Madagascar). Considering the sustained COVID-19 impacts compounded with the cost barriers that young people already experience, it is vital to ensure that resources and funds are allocated to support sexual and reproductive services for young people.

Results from the survey indicate that COVID-19 had a significant impact on young people's access to sexual health care across all regions. Many young people from Africa, Asia and Oceania, Europe and North America, and Latin America expressed they could not access services because health centers diverted their resources to COVID-19 responses.Youth from Asia and Oceania, and Africa expressed that services were closed

down due to the pandemic, movement restrictions, and lockdowns in their area, making it difficult for youth to access essential health services. There was also fear of infection if they were to attend a clinic. For example, one participant expressed that *"as advocates we were not able to reach out to our target groups. Women had zero access to health services and the marginalized communities were put at risk"* (Youth Participant, India).

Youth from Europe, North America, and Latin America who reported barriers to sexual health care during the pandemic period noted difficulties scheduling routine appointments and receiving medication such as HIV antiretrovirals and contraceptives. Participants from all regions reported receiving information about sexuality education through online resources. These results indicate the pressing need to strengthen pandemic resilience and address gaps in access to sexual and reproductive health services to ensure continued and uninterrupted care.

FACILITATORS TO ACCESS CSE

Youth from all regions expressed that peer education positively impacted their sexuality education and identified it as one of the most effective channels for delivering CSE. Youth expressed that peer educators in both in-school and out-of-school programs provided them with a space to have open and comfortable discussions about their sexual health and wellbeing. One of the participants stated, *"I learned most of my sex ed with queer friends and networks in the community... Community-led sex ed is also important to young queer sex workers who have no access to school"* (Youth Participant, Philippines). Another participant expressed, *"I trusted established groups and organizations to access [sexuality education]. I also learned a lot from the youth led groups I worked with"* (Youth Participant, India). These findings suggest the importance of implementing peer-based education that is tailored to young people's needs. Peer-based education may be more effective when integrated into holistic interventions and when it focuses on eliminating stigma and making referrals to experts and services (Chandra-Mouli et al., 2015). Peer-based education also offers tailored and effective approaches to reach marginalized populations (UNFPA, 2020).

Young people also reported using online resources to access sexuality education, such as articles, forums, research materials and social media. However, youth had mixed experiences using online resources. Some participants expressed that they were able to access information online easily. For example, one of the respondents expressed, *"self learning and online material helped me to learn more about sexuality. It was accurate and evidence based. Mainly from Journals, sex educators, research materials and other online content. It had a positive impact "* (Youth Participant, India). However, some participants also expressed that although information was readily available online, they felt confused and did not find the information to be reliable. For example, one participant expressed, *"I researched online trying to rely only on medical sites, however I did sometimes find blogs and I got very confused with the opinions and information shared there"* (Youth Participant, Mexico). Given the increasing use of digital media by young people, online platforms provide an opportunity to disseminate information on sexual and reproductive health information in settings where youth have access to the internet. However, there is a lack of oversight and control over the quality of information provided online, making it difficult for individuals to distinguish between accurate and inaccurate information (UNESCO, 2020; UNESCO, 2018). Given this information, creating digital education platforms and complementing information provided by educators such as facilitators, health professionals, and teachers with online resources may enable meaningful ways to deliver sexuality education.

Youth also often reported that health care providers were trusted sources of SRH

information, as they felt that the information they received from health care providers was accurate and reliable. Given healthcare providers' role in providing sexual and reproductive health information, it is vital to ensure health providers are trained to provide youth-friendly services. Health providers can be an essential link between comprehensive sexuality education and health services (UNESCO, 2018).

KEY GENDER CONSIDERATIONS

The survey has revealed several critical considerations regarding gender and comprehensive sexuality education. To provide inclusive and empowering sexuality education to all youth, including gender diverse, queer, and trans youth, gender identities and non-heterosexual experiences must be integrated and amplified. This includes the creation of positive and supportive environments that allow for gender diverse, queer, and trans youth to discuss and receive accurate information on topics that reflect and reinforce their unique experiences. Further, information on gender identity, expression and sexual orientation should be accessible and integrated into all CSE curricula.

Multiple challenges experienced by gender diverse, queer, and trans youth were communicated by survey participants. In fact, surveyed queer, trans, and sexually diverse youth unanimously reported the lowest level of satisfaction (1 out of 5) with in-school sexuality education, raising concern for the quality and relevance of traditional sexuality education for this group. Further, youth agreed that topics surrounding gender identity and 2SLGBTQQIA+ bodies and sexual experiences were not covered in school-based sexuality education but would have been valuable to their learning. As one respondent noted, *"the institutionali[z]ed sexuality education focuses the conversation on reproduction of cisgender heterosexual people and excludes any conversations on queer and trans bodies"* (Youth Participant, Philippines).

In addition, the focus of traditional sexuality education on intercourse and pregnancy, without recognition of other aspects of sexual experiences that pertain to all genders, is gender-exclusive and heteronormative. One respondent said, *"[My] education focused only on sex for procreation (therefore heterosexual sexuality). We did not learn anything about pleasure, consent, other sexual identities or sexualities, etc."* (Youth Participant, Canada). Incorporating topics relevant to all genders, such as consent, queer relationships, and pleasure, would create a more inclusive and relevant sexuality education experience.

Out-of-school sexuality education is an alternative to traditional approaches for queer, trans, and gender diverse youth, as out-of-school approaches were ranked higher than school-based sexuality education. One respondent noted that *"out of school education... was much more inclusive and talked about the LGBTQ+ perspective"* (Youth Participant, Canada). However, while friends are a common and perhaps more accommodating sexuality education resource for queer, trans, and gender diverse youth, consulting friends can propagate misinformation and lead to confusion. One respondent said, *"I learned most of my sex ed with queer friends and networks in the community. Of course some of those that I learned were not true but most of what I learned was their lived experience of navigating their sexuality and how they wanted us to learn from their triumphs and mistakes"* (Youth Participant, Philippines). While learning from other's lived experiences is valuable, there remains an important consideration toward caution as everyone experiences sexuality differently and not all experiences may be generalized as evidence-based and accurate information. In addition, these approaches may not be accessible to all youth, as it may be hard for queer, trans, and gender diverse youth to create networks on their own, especially in regions for 2SLGBTQQIA+ people are criminalized and marginalized due to their sexuality. One respondent described their

experience moving to a different city, saying that *"information of sexuality is scarce because I had to move from my rural hometown, to the city, which I didn't had the chance to build or belong in a noncis nonhet community"* (Youth Participant, Philippines).

Fostering acceptance and enabling the creation of positive environments is crucial for gender diverse, queer and trans youth, especially those in regions where aspects of gender diverse communities may be opposed and stigmatized. For example, one respondent described, *"policy makers...are highly concerned about the contents of CSE, particularly on sexuality orientation. Such topics, if not others, are highly debated not to be mentioned in school, and the CSE nomenclature has remained a futile exercise in the attempt of integrating CSE into the...school curriculum"* (Youth Participant, Ethiopia). Government policies and priorities cascade to the community level dictate school-based sexuality education. As one respondent noted, *"we were told very clearly by the teacher that the government policies meant they were unable to "promote homosexual activity" in these classes. While she was obviously critical, it obviously stopped her from giving us any information about LGBT relationships and sex which is a massive issue"* (Youth Participant, United Kingdom). The policy in which this participant is referring to (Section 28 of the Local Governments Act) was repealed in the United Kingdom in 2003. However, Such information highlights the importance of ensuring that new and updated policies are being implemented across all school settings. Concrete steps must be made to ensure that curricula are updated, and that educators are following the new standards that have been implemented. Efforts need to be made not only to repeal policies, but also to combat the negative impacts it has in future delivery of education even after they have been repealed.

Familial relations are deeply rooted in cultural and social norms. Young people's access to empowering sexuality education may also be influenced by familial values and beliefs. One respondent explained that they *"experienced conversion therapy and masked it as a religious/spiritual awakening"* (Youth Participant, Philippines). This demonstrates the importance of safe and supportive spaces for young people to learn and discuss gender identity, sexuality, and sexual expression. While sexual health and wellbeing are different for everyone, young people need to receive sexual health information that reflects the experiences of all gender identities and expressions. One respondent described, *"When I was coming out at the age of 12 I was taught that there were either people who were "Straight" or "Fully Gay" (yes I used the term fully gay which was used by people in the society), we did receive any sex education where we were taught about all other sexualities that existed. Now I'm 18 and I identify as pansexual which is still less known to people"* (Youth Participant, India).

In order to reflect the interests and needs of all youth, sexuality education must consider gender diverse youth and the unique health experiences of all gender identities. Both in-school and out-of-school sexuality education needs to be safe and inclusive. It must be accurate, comprehensive and relevant so that youth, no matter their gender, are equipped to make informed decisions about their bodies and lives.

KEY CONSIDERATIONS FOR YOUNG PEOPLE WITH DISABILITIES

100% of youth that identified as having a disability reported utilizing sexual health services in the past two years, and a majority of them rated sexual health service delivery at a 1 out of 5. They overall ranked their in-school sexuality education satisfaction at a 2 out of 5 and their out-of-school sexuality education satisfaction at a 3 out of 5, indicating opportunities for improvement in sexual health services and education for persons with disabilities. While there was low participation of persons with disabilities in the survey,

their input is crucial to the development of SRHR services and resources. According to the WHO, persons with disabilities are often overlooked in SRHR. This was echoed by one respondent who felt that *"ableist society...does not recognize young women with disabilities as sexual beings"* (Youth Participant, South Africa). They also noted that "Persons with disabilities should be thought of and included in the education."

KEY CONSIDERATIONS FOR INDIGENOUS YOUTH

While there was low participation of Indigenous youth in the survey, their voices are necessary in the development of CSE and SRHR resources. Lived experiences particular to Indigenous groups, such as ongoing colonial legacies and trauma including trauma related to the control of Indigenous reproduction by institutions, are essential to consider in SRHR (Saskatoon Sexual Health, n.d.), for they impact the accessibility of sexual health services. According to the United Nations Inter-Agency Support Group, disempowerment and discrimination are two primary factors inhibiting SRHR access for Indigenous communities (IASG, 2014). Access to education, affordable health care, willingness to access public health services, and other social determinants of health are all impacted by systemic discrimination. In addition, there is evidence that Indigenous women and girls in Latin America, Africa, and South Asia and the Pacific are more significantly affected by child marriage, FGM/C, and other forms of gender-based violence (GBV) (IASG, 2014).

The perspective of two-spirit people must also be considered in SRHR dialogue. Two-spirit is a gender-diverse community that is specific to Indigenous peoples, and the meaning of two-spirit is different for each person that identifies as such (Saskatoon Sexual Health, n.d.). In order to address the unique circumstances of two-spirit people, their voices must be centred.

The low survey response rate from persons with disabilities and Indigenous communities is a limitation to this report and must be acknowledged. As a result, there is a critical and pressing need for additional research, for communities, completed by communities, to ensure culturally safe and relevant SRH calls to action.

PERSPECTIVES FROM OLDER ADULTS

Despite lower representation in the Global CSE Survey, older folks recalled their experience with sexuality education. Of respondents aged 30 years and older, 57% reported receiving some level of sexuality education in school. This number increased to 78% for out-of-school sexuality education. Overall, this group reported low and moderate satisfaction with their sexuality education experience, as 90% of respondents reported level 3 of satisfaction or lower. However, this group may also have been likely taught when abstinence and avoidance of negative sexual health outcomes were the primary principles of sexuality education, with little support in equipping young people "to take control and make informed decisions about their sexuality and relationships freely and responsibly" (UNESCO, 2018).

Most respondents recalled learning of puberty, safer sex practices, menstruation, HIV and other STIs, and pregnancies. One respondent from Mexico reflected and shared that, *"No one talked to me about pleasure, abortion nor consent. Gender identity, sexual orientation and gender-based violence were totally unheard of. Being sexually active and/or having multiple sexual partners was frowned upon."* One respondent from Canada shared, there must be a focus on consent *"instead of focus on abstinence..."*. Alongside consent, other pressing issues identified by older folks were GBV, early and/or unplanned pregnancies, combatting cultural taboos and myths, services access, and the inclusion of 2SLGBTQQIA+ experiences.

Most participants also supported earlier and age-appropriate introduction to sexuality education. While the predominant response called for introduction to sexuality education to occur before puberty, others called for children to be initiated into CSE as early as possible. This was especially referenced with respect to informing and protecting children from sexual harassment and violence, as one respondent wrote, *"since our childhood we start our self-recognition but stereotypes have made us see it as something dirty, bad and there is no practice that helps us to recognize our intimate parts and that they are proper of the person, this contributes to reduce the rates of abuse in younger age"* (Participant, Guatemala). Nonetheless, all respondents reported that CSE is important to them and recognized that CSE is essential to young people's sexual health and wellbeing. Participants called for mandatory integration of CSE in schools through complementary training for teachers and external support to better support students' sexuality education.

Respondents recognized that CSE remains highly contested in many contexts, with the politicization of CSE reflected in futile attempts toward the integration of CSE in school curricula. When considering the future of CSE, the principal hopes shared by this group were reduction in early and unplanned pregnancies, expanded access to contraceptive methods for all, *"... a significant drop in gender-based sexual violence and to make it safe for the LGBT+ community to express their gender identity in whichever way they choose to. We want free, safe and legal abortion"* (Participant, Mexico). Numerous respondents called for amplified and contextualized commitments to CSE, with one respondent from Ethiopia stating, *"I don't think sufficient effort [is] undertaken... we seem to have left the issue to international NGOs."* There were also calls for diversification in topics, especially toward the recognition and inclusion of non-heteronormative views, particularly surrounding gender identity, sexual orientation and Indigeneity.

CALLS TO ACTION

1. Sexuality education **must** become more comprehensive, accessible, youth-friendly, inclusive, and reflective of young people's needs, intersecting identities, experiences and realities as well as local and regional contexts.

2. Government officials as well as community-based entities must take proactive actions to **normalize** sexuality education in both school spaces and out-of-school settings.

3. Government officials must actively address barriers that hinder access to sexual health services and comprehensive sexuality education. This must include the **revision of policies, laws and curricula limiting or impeding on such access.**

4. Reflective of young people's needs as well as local and regional contexts, government officials must actively address **barriers** associated with providing and receiving comprehensive sexuality education in out-of-school settings. This entails expanding, broadening, strengthening and prioritizing access to comprehensive sexuality education in out-of-education-spaces, including community-based organizations and resources.

5.Reflective local and regional contexts, government officials must actively address **internet connectivity** and access barriers which are creating a digital divide between youths and limiting their access to digital-based comprehensive sexuality education.

6. Youth must be actively and meaningfully **engaged and mobilized** in the processes and decisions related to the establishment or review of comprehensive sexuality education. Their voices, experiences, needs, opinions, realities, wishes, and demands must be heard, valued, respected and at the center of decision-making processes.

7. Government officials must actively and adequately train and strengthen **the capacity** of those interested in teaching and those needing to teach comprehensive sexuality education, including although not limited to, teachers, community workers, health-care providers, and family members.

8. Government officials must fund both comprehensive sexuality education and sexual health services in a way that is needs-based, **sustainable** and consistent with the principle of substantive equality. The funding should reflect and remediate the impacts related to the COVID-19 pandemic on sexual health care and education.

LIMITATIONS

This section outlines the limitations which impact the analysis and interpretation of survey results. It is essential to note these limitations as they impact the findings and conclusions made in this report.

First, the survey was only available in four languages (English, French, Spanish and Portuguese), which restricted access to those only with knowledge of these languages. This impacted the sample size and the ability to receive and share experiences from various parts of the world.

Secondly, the marketing and period of the survey was limited, thus reaching only a number of people and impacting the sample size. Such sample size limits the readers' ability to make broad conclusions or generalizations.

Third, the COVID-19 pandemic may have impacted some people's ability to answer the survey due to, although not limited to, one's health or well-being and limited time, resources, and access to the internet.

Access to the internet alone is the fourth limitation of the survey as one must have internet access to complete the latter. This impacted the ability to receive and share experiences from various parts of the world where internet bandwidth is not accessible. Additionally, participants would have to have access to a computer or smart device to access this survey. This poses an obstacle for many communities living with minimal access to electricity or living in rural regions.

Participants were not compensated for their time and participation, which may have refrained some from participating in the survey.

Lastly, sexuality education is a taboo topic that is often stigmatized in many regions of the world, which may have limited some people to want or participate.

These limitations highlight and showcase the need for additional and ongoing research within the realm of youth perspectives on comprehensive sexuality education.

Conclusion

The survey enabled the IYAFP Canada and the Youth Coalition to compile answers and identify trends and findings that give a better notion of the experiences, needs and realities surrounding CSE for youths across the globe. Overall, the survey focused on four major domains: i) sexuality education and health service access, ii) CSE in schools and community, iii) experiences in learning CSE, and iv) implications for CSE in future. These domains were further explored to identify the experiences and realities of young people surrounding the utilization, accessibility and experience of sexual health services, the impact of COVID-19 on sexual health care, and the introduction, content, overall experience, regional considerations and future related to CSE both in and out of education spaces.

Although the findings cannot be generalized to countries or regions, this report highlights the need for entities to take proactive action toward making CSE more accessible globally for youths. Indeed, much work remains to be done in sexuality education globally and even if there are various similarities between regions found in this report, there is no one-size-fits-all approach to comprehensive sexuality education. Various entities, including government and political officials, community-based entities, and religious entities, must take proactive steps to address the many barriers associated with accessing and providing sexual health services and comprehensive sexuality education in their region to enable youth to have meaningful and satisfying sexual lives. Undeniably, youth must be at the center of processes and decisions related to establishing or reviewing comprehensive sexuality education. They must be actively and meaningfully engaged and mobilized for their voices to be heard and for change to grow.

Youth know their needs best. It is time people listen and value young people's needs, experiences, wishes and demands.

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