

Systematic Review

Effectiveness of Comprehensive Sexuality Education to Reduce Risk Sexual Behaviours Among Adolescents: A Systematic Review

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Abstract: Background: Adolescence is a critical life period marked by significant vulnerability to risky sexual behaviours. Comprehensive sex education offers better sexual and reproductive health to adolescents. Aim: We aimed to analyse the effectiveness of sex education interventions on reducing risk behaviours among adolescents. Methods: A systematic peer review was conducted. The databases consulted were PubMed, Scopus, Web of Science, and CINAHL. The inclusion criteria were as follows: randomized clinical trials published between 2013 and 2023 and methodological quality ≥ 5 points as per the Van Tulder scale. Results: A total of 255 studies were identified, with 25 finally selected. Of them, sixteen dealt with non-condom use, one was about early sexarche, and eight combined several risk behaviours. There was predominance of in-person teaching at schools with lectures and varied activities. The sample was predominantly comprised by girls aged between 14 and 16 years old. Certain variability regarding content, technique, number of sessions, duration, locus, and teaching modality and staff was observed in the comprehensive sex education interventions. Almost all the interventions were effective in reducing risky sexual behaviours; however, two studies failed to achieve a reduction in risky sexual behaviours.

Keywords: adolescent; health risk behaviours; sex education; randomized controlled trial



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1. Introduction

Sex education is defined as an educational process that enhances understanding of the functional, structural, and behavioural dimensions of human reproduction [1]. The concept of sex education is broad, subject to ongoing debate, and must be tailored to the learner's age or developmental stage. It is typically integrated as a multidisciplinary subject within the curriculum [2]. This approach contributes to improve sexual and reproductive health by preventing risk behaviours, including reduction in sexually transmitted infections (STIs) and unintended pregnancies. Furthermore, it promotes gender equality and equal social norms and supports informed participation in practices and decision making regarding adolescents' exercise of sexuality [3,4].

Among the factors contributing to deficiencies in sexual education are the following: misinformation; evasion of parents' responsibility; underestimation by parents of their children's sexual needs or capacities; embarrassment or lack of preparedness to address

the topic; insufficient information provided within the school environment; reliance on the internet for information without the ability to critically evaluate sources; and the influence of mass media (such as television and music) in disseminating distorted messages [5]. Additionally, there is a lack of adequately trained professionals to deliver comprehensive care, insufficient facilities and resources within schools and communities, and a pressing need to establish effective prevention and treatment services [6].

Sexuality education programmes can be categorised into three types: (1) programmes that focus primarily on abstinence from sexual intercourse; (2) programmes that include abstinence as an option while also addressing contraception and safe sex practices, commonly referred to as comprehensive sexuality education (CSE); and (3) programmes that incorporate elements of type 2 alongside components related to personal, developmental, and sexual growth, referred to as holistic sexuality education [2]. The present study is based on type 2.

CSE is a process that encompasses a curriculum designed to address the cognitive, emotional, physical, and social dimensions of sexuality. Its purpose is to provide adolescents with a wide range knowledge, skills, attitudes, and values, enabling them to maintain good health, well-being, and dignity; establish respectful social and sexual relationships; understand how their choices impact their own well-being and that of others; recognise their rights; and ensure their protection throughout life. Furthermore, research has indicated that the absence of CSE contributes to adolescents engaging in sexual activity at earlier ages and participating in risky sexual behaviours. Conversely, it has been demonstrated that CSE does not increase sexual activity, risky behaviours, or the prevalence of HIV or other STIs [7]. However, there is significant variability in the implementation and development of sexuality education within schools [2,8,9].

Adolescence is a stage characterized by numerous changes, during which individuals often experience insecurity, seek acceptance from their peer group, and are easily influenced by their peers' opinions as they approach adulthood [10]. While biological changes are relatively consistent across the globe, psychological and social transitions are largely shaped by the environment and individual circumstances [11]. This stage is marked by adolescents' search for and construction of their own identity, where peer groups often become the primary point of reference, replacing the family, which served as the central axis during childhood [5,11]. It is a critical period for acquiring and solidifying a lifestyle, during which both healthy and harmful habits are established and reinforced. The desire for acceptance and a low perception of risk can lead to behaviours that pose significant health risks, resulting in considerable consequences in terms of morbidity, mortality, and social costs. Consequently, prevention during this period is a fundamental priority in public health [10,12].

Risky sexual behaviour refers to situations in which an individual is exposed to risks affecting their physical and emotional well-being in the context of sexuality. Risky sexual behaviours among adolescents may include the following: (1) early initiation of sexual activity; (2) having a higher number of sexual partners; (3) frequent change of partner; and (4) inadequate or non-use of protective measures during sexual practices [13,14]. Furthermore, gender inequality is prevalent during this stage, highlighting the importance of addressing sexual behaviours from an interpersonal perspective that accounts for gender differences [15].

In 2017, approximately 1.8 million adolescents worldwide were living with HIV [7]. Other STIs, such as syphilis, gonorrhoea, chlamydia, and trichomoniasis, rank among the most common causes of illness globally [16]. According to Moreno et al. [17], approximately 50% of new STIs cases, both globally and within Europe, occur among individuals aged 15

to 24 years. These infections are more prevalent in girls than in boys, with an almost 2:1 ratio, although this disparity tends to equalise around the age of 20.

Given the aforementioned considerations, the objective of this review is to address the following question: Are CSE interventions effective in reducing risky sexual behaviours among adolescents?

2. Materials and Methods

A systematic review was conducted in accordance with the recommendations outlined in the Cochrane Handbook and the 2020 PRISMA statement [18,19]. The review was registered at PROSPERO (Ref.: CRD42023416088).

2.1. Eligibility Criteria

The studies had to meet the following inclusion criteria: (1) studies addressing the effectiveness of CSE in reducing risky sexual behaviours among adolescents; (2) studies published within the last ten years (2013–2023); and (3) study design: randomized clinical trial (RCT).

The studies were excluded if (1) they were RCTs that did not present results (e.g., pilot RCTs) or (2) they scored below 5 on the Van Tulder scale for methodological quality assessment [20,21].

2.2. Information Sources and Search Strategy

The databases consulted were PubMed, Scopus, Web of Science, and CINAHL. The search was conducted in April 2023 and completed in May of the same year.

To implement the search strategy across the different databases, Medical Subject Headings (MeSH) descriptors and related terms were used, which were linked through the application of Boolean operators. The search strategy was as follows: “Sex Education” AND Adolescent AND “Randomized Controlled Trial”. Synonyms (Entry Terms) for the same descriptors were also considered to maximise the number of potentially eligible studies. The search strategy was applied across the consulted databases by two reviewers to ensure greater objectivity [22].

2.3. Selection Process

Three screening stages were conducted to select the studies. In the first stage, two reviewers independently assessed the studies based on their titles and abstracts, excluding duplicates. The reviewers then engaged in a discussion to reach consensus on the studies to be included based on the results of the first screening stage. In the second stage, both reviewers performed a critical full-text review of the selected studies; a subsequent discussion was held to reach agreement on the studies to be included [23]. In the third stage, the methodological quality of the studies was assessed [24]. Any discrepancies between the reviewers were solved through discussion, with a third reviewer involved in case of disagreement.

2.4. Data Items and Extraction

Data extraction was performed according to the review question, with the results presented in various tables. One table describes the characteristics of the studies, including the following data: (1) authors; (2) period/location; and (3) sample (ages, genders) in the control group (CG) and the intervention group (IG). Another table presents the implemented interventions and their effectiveness.

2.5. Quality Assessment

The methodological quality assessment was conducted using the Van Tulder scale, which consists of eleven items for evaluation. Each item has three possible responses, with one point awarded for a “Yes” answer and no points for “No” or “I don’t know” answers. Studies with of five or higher are considered to have high methodological quality [20,21]. Therefore, only RCTs that met this criterion were included (Table 1).

Table 1. Van Tulder scale to evaluate the methodological quality of ECA.

Items	Answers and Scores		
	Yes	No	Don’t Know
A. Was the randomization method appropriate?	1	0	0
B. Was the treatment allocation concealed?	1	0	0
C. Were the groups similar at baseline regarding the most important prognostic indicators?	1	0	0
D. Were the patients blinded to the intervention?	1	0	0
E. Was the care provider blinded to the intervention?	1	0	0
F. Was the timing of the outcome assessment in all group similar?	1	0	0
G. Were co-interventions avoided or similar?	1	0	0
H. Was the compliance acceptable in all groups?	1	0	0
I. Was the drop-out rate described and acceptable?	1	0	0
J. Was the timing of the outcome assessment in all group similar?	1	0	0
K. Did the analysis include an intention-to-treat analysis?	1	0	0

Sources: [20,21].

3. Results

3.1. Study Selection

The search yielded 255 studies, of which 25 were finally included (Figure 1).

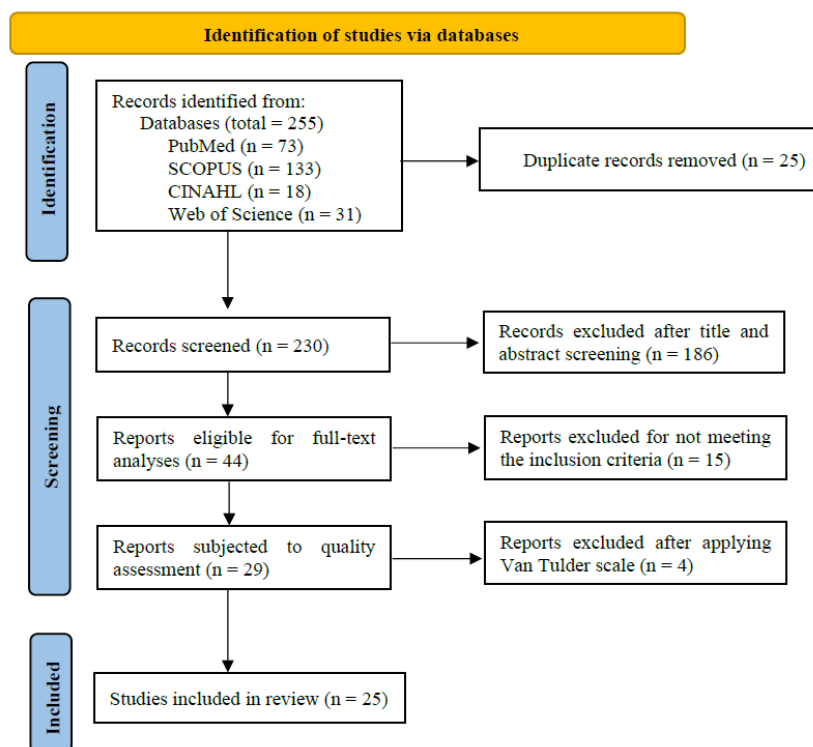


Figure 1. PRISMA flow diagram of study. Source: the authors.

3.2. Characteristics of the Sample

Table 2 summarises the characteristics of the adolescent sample receiving CSE, as described in the studies. In all the studies, the samples consisted of adolescents, aged between 13 and 16 years in 76% of cases [25–43]. Regarding gender, 24% of the studies had samples exclusively comprising women [29,33,37,42–44]. In the remaining studies, the samples included both men and women, with a predominance of females in 68.42% of cases [25,26,28,32,34–36,40,41,45–48]. In regard to the countries where the studies were conducted, 48% were from North America [25,26,37–43,45,47,49].

Table 2. Characteristics of the samples of adolescents that are taught CSE.

Authors	Period/Location	Sample (Ages, Genders)
Barbee et al. [25]	The study period encompassed 31 months, from the end of 2011 to 2014, collecting follow-up data until 2015. Extracurricular activities were carried out in a camp organized by 23 youth service organizations. USA.	1448 adolescents aged between 14 and 19 years old, with a mean of 15.72; 63% were women, and 37% were men. IG-RR: 515. IG-LN: 511. CG-PW: 422.
Barbee et al. [26]	The study period was between September 2011 and March 2014. Extracurricular activities were carried out in a camp organized by 23 youth service organizations. USA.	1208 adolescents aged between 14 and 19 years old, with a mean of 15.72; 63% were women, and 37% were men. IG-RR: 431; 63.6% women and 36.4% men, with a mean age of 15.77 years old. IG-LN: 412; 64.32% women and 35.68% men, with a mean age of 15.69 years old. CG-PW: 365; 62.27% women and 37.73% men, with a mean age of 15.71 years old.
Espada et al. [27]	The study period corresponded to 2012, in 18 high schools and during class hours. Spain.	1563 adolescents aged between 14 and 16 years old, with a mean of 14; 51.1% were men, and 48.9% were women. IG-C1 (IG-COMPAS): 622; 51.8% were men, and 48.2% were women. IG-C2 (IG-Cuídate): 442; 55.4% were men, and 44.6% were women. CG: 499; 46.3% were men, and 53.7% were women.
Gómez-Lugo et al. [28]	Study period not specified. Colombia.	2047 adolescents aged between 14 and 19 years old, with a mean of 15.24; 52.1% were women, and 47.9% were men. IG 891 (8 schools): 55.25% women and 44.75% men. CG 1156 (6 schools): 49.8% women and 50.2% men.
Hegdahl et al. [29]	The study period was from July 2016 to 2018, with a two-year follow-up period from 2018 to 2020, in 157 7th-grade schools. Zambia.	4922 female adolescents, with a mean age of 14.1 years old.
Hu et al. [30]	The study period was between October 2018 and December 2019 in 29 high schools from Yunnan and Guangdong. China.	3151 male and female adolescents. IG: A total of 1760 students with a mean age of 16.13 years old; 47.44% were women, and 52.56% were men. IG: A total of 1391 subjects with a mean age of 16.04 years old; 44.93% were women, and 55.07% were men.

Table 2. Cont.

Authors	Period/Location	Sample (Ages, Genders)
Jerlström and Adolfsson [31]	The study period was between December 2019 and March 2017, in 8th-grade schools. Sweden.	963 adolescents aged 15 years old; 49.52% were women, and 49.88% were men. IG: 497; 50% were women, and 50% were men. CG: 466; 49% were women, and 50% were men.
Lohan et al. [32]	The study period was from 1 February 2018 to 6 March 2020, in 62 schools. United Kingdom.	6556 adolescents aged 14–15 years old. IG: 4100; 51.70% were women, and 29.48% were men. CG: 4116; 45.48% were women, and 51.53% were men.
Mbizo et al. [33]	The study period was between August 2017 and December 2020, in high schools and health facilities from the Solwezy and Mufumbwe districts. Zambia.	986 female adolescents; 54.8% were aged 15–19 years old (with a mean of 15 in a range from 12 to 24). IG-1: A total of 245 students. IG-2: A total of 354 students. CG-2: A total of 287 students.
Millanzi, Kibusi, and Osaki [34]	The study period was between September 2019 and September 2020, in 12 high schools. Tanzania.	660 adolescents aged between 12 and 19 years old, with a mean of 15; 57.5% were women, and 42.5% were men.
Millanzi, Kibusi, and Osaki [35]	The study period was between September 2019 and September 2020, in 12 high schools. Tanzania.	660 adolescents aged between 12 and 19 years old, with a mean of 15; 57.5% were women, and 42.5% were men.
Morales et al. [36]	Study period not specified. Spain.	699 adolescents aged between 14 and 16 years old, with a mean of 14.66; 53.6% were women. IG: 379; 31.7% women and 48.3% men, with a mean age of 14.63 years old. CG: 320; 55.9% women and 44.1% men, with a mean age of 14.71 years old.
Morrison-Beedy et al. [37]	Study period not specified. USA.	639 women adolescents aged between 15 and 19 years old, with a mean of 16.5. IG: 329. CG: 310.
Oman et al. [38]	The study period was from 2012 to 2014, in 14 group homes. USA.	1036 adolescents included in the system living in group care homes and aged 13–18 years old, with a mean of 16.1 considering both groups; 79% were men, and 21% were women. IG: 517; 78.9% were men, and 21.1% were women. CG: 519; 78.4% were men, and 21.6% were women.
Oman et al. [39]	The study period was from 2012 to 2014, in 14 group homes. USA.	1037 adolescents included in the system living in group care homes and aged 13–18 years old, with a mean of 16.2 considering both groups; 82% were men, and 18% were women. IG: 517; 81.5% were men, and 18.6% were women. CG: 519; 77.9% were men, and 22.1% were women.

Table 2. Cont.

Authors	Period/Location	Sample (Ages, Genders)
Philliber et al. [40]	The study period was between February 2019 and March 2020. USA.	1401 LGBTQ adolescents and young individuals aged between 14 and 22 years old, with a mean of 16.
Tingey et al. [41]	The study period corresponded to the summers of 2011 and 2012, in 2 basketball camps for 8 days. USA.	267 adolescents aged between 13 and 19 years old, with a mean of 15.1; 56% were women, and 44% were men.
Widman et al. [42]	The study period was during autumn 2015, in 4 high schools. USA.	222 female adolescents aged between 12 and 16 years old, with a mean of 15.2. IG: 107/CG: 115.
Ybarra et al. [43]	The study period was from 24 January 2017, to 12 January 2018, with enrolment by telephone. USA.	948 cisgender girls aged between 14 and 19 years old, with a mean of 16.1. IG: 473, with a mean age of 16.14 years old. CG: 475, with a mean age of 15.97 years old.
Yakubu et al. [44]	The study period was between April and August 2018, in 6 high schools. Ghana.	363 single female adolescents aged 13–19 years old. IG: 183; 22.8% were aged 14–16 years old, and 77.2% were between 17 and 19 years old. CG: 180; 16.9% were aged 14–16 years old, and 83.1% were between 17 and 19 years old.
Manaseri et al. [45]	The study period was between autumn 2011 and spring 2013, in 34 schools. Hawaii.	1783 adolescents aged between 11 and 13 years old, with a mean of 12; 52% were women, and 48% were men. IG: 1158. CG: 625.
Mathews et al. [46]	The study period was between February and March 2013, in 8th-grade high schools. South Africa.	3451 adolescents with a mean age of 13 years old. IG: 1748; 37.9% were men, and 62.1% were women. The mean age was 13.7 years old. CG: 1703; 41.5% were men, and 58.5% were women. The mean age was 13.71 years old.
Tingey et al. [47]	The study period was between 2016 and 2018, in a summer camp. USA.	534 adolescents aged between 11 and 19 years old, with a mean of 13.27.
Wong et al. [48]	The study period was between November 2009 and October 2014. Singapore.	688 heterosexual adolescents aged between 16 and 19 years old, with a mean of 18. IG: 337; 44.51% were men, and 55.49% were women. CG: 351; 43.3% were men, and 56.7% were women.
Manlove et al. [49]	The study period was between autumn 2019 and autumn 2018, in 57 classrooms from 3 schools. Texas.	621 adolescents aged 13–17 years old. IG: 347; 33.2% women and 46.8% men, with a mean age of 13.85 years old. CG: 279; 49.4% women and 50.6% men, with a mean age of 13.86 years old.

Source: The authors. CG: control group; IG: intervention group; RR: Reducing the Risk; LN: Love Notes; PW: Power of We; HIV: human immunodeficiency virus; CSE: comprehensive sexuality education; PBP: problem-based pedagogy; LGBTQ: lesbians, gays, bisexuals, transgenders, and queers; SRH: sexual and reproductive health.

3.3. Study Results

Table S1 presents the findings and effects sizes related to the characteristics of the risky sexual behaviours, interventions, and the effectiveness of sexuality education as reported in the studies. All of the aforementioned are analysed in the sections below.

3.3.1. Sexual Risk Behaviours

Among the risky sexual behaviours in adolescents described in the studies, 64% reported non-use of condoms [25,27,30–34,38–44,47,49], with sociocultural inequality, limited sexual knowledge, and difficulty accessing resources due to economic hardship identified as contributing factors in 62.5% of cases [25,32,33,38,39,41,42,44,47,49].

One study highlighted early sexual debut as a risky behaviour, with limited sexual knowledge cited as the reason [45]. The remaining studies presented a combination of various risky behaviours, namely non-use of condoms, multiple partners, and early sexual debut [26,28,29,35–37,46,48], with limited sexual knowledge identified as the reason in 37.5% of cases [35,36,48].

3.3.2. Comprehensive Sexuality Education Interventions

All the interventions employed in the studies were based on CSE. Regarding the contents of the interventions, 40% of the studies focused on preventing unwanted pregnancies through condom use [25,32–34,38–40,43,44,49]. The thematic learning of all studies is described in Table S1. In terms of the techniques used, 56% of the studies employed classes and activities such as role-playing, where real-world problems were posed, and participants responded based on what they had learned; brainstorming about health promotion or sexual risk; debates followed by a discussion of the different risky behaviours identified; and/or skills practice related to the correct use of condoms or communication strategies for negotiating condom use and handling sexual pressure from a partner [27–29,31,34–39,41,42,44,47].

Regarding the number of sessions, 60% of the adolescents included in the studies attended from 3 to 10 CSE sessions [27,28,30,32,36–39,41,42,44,45,47–49]. In terms of session duration, 96% of the studies reported sessions lasting between 45 and 90 min [25–39,41–49].

As for the setting of the interventions, 76% of the studies indicated that they were conducted in schools [25–32,34–37,40,42,44–46,48,49]. Regarding the delivery method, 84% used in-person sessions [25–29,31–41,44–47,49]. In terms of the facilitators, 40% of the studies reported that the interventions were led by facilitators specifically trained by the research team [27,29,37–41,44,47]. The remaining 60% were conducted by various professionals, including teachers, psychologists, health promoters, parents of adolescents, social workers, doctors, and/or nurses, all of whom were trained by the research team prior to the intervention [25,26,28,30–36,42,45,46,48,49].

3.3.3. Effectiveness of the Interventions

In 96% of the selected studies, the interventions focused on training participants in the use of condoms and contraceptive methods to prevent unwanted pregnancies, HIV, or other STIs. Among these, results demonstrated changes in knowledge and attitudes, with 83.33% reporting that adolescents in the IG showed improved knowledge, skills, attitudes, and self-efficacy regarding condoms or contraceptive use during sexual activity compared to the CG [26–32,34–36,38–44,46,47,49]. In two studies [40,49], the IG reported an increase in medical appointments and greater awareness of where to access contraceptives compared to the CG. Additionally, one study described that the IG showed a higher intention to purchase, use, and negotiate condom use under the influence of alcohol or drugs compared to the CG [27].

A total of 66.67% of the studies targeted the prevention of unwanted pregnancies through training in condom use [25,26,28,30,32–35,37–40,43,44,47,49]. Among these, results demonstrated changes in knowledge and attitudes. Two studies specifically focused on improving knowledge and attitudes, finding that the interventions increased awareness of sexual abstinence and the intention to practice it in the IG compared to the CG [37,44].

Similarly, other studies showed that the IG demonstrated increased sexual assertiveness and improved skills in adopting protective practices to reduce unintended pregnancies compared to the CG [26,28,32,34,35,39,40,43,47]. Finally, only three studies reported changes in behavioural skills, describing the interventions as effective in reducing the number of cases in the IG compared to the CG [25,33,37].

A total of 41.67% of the studies focused on preventing HIV or other STIs through condom use training [27,28,30,31,36,41,42,46–48]. Among these, several reported improvements in knowledge and attitudes. Six studies indicated that participants in the IG exhibited better knowledge, attitudes, and risk perception regarding HIV and other STIs compared to the CG [27,28,31,36,42,46]. In two additional studies, the IG demonstrated increased sexual assertiveness and enhanced skills in adopting protective practices to mitigate the risk of HIV and other STIs compared to the CG [41,47]. Furthermore, one study successfully improved healthy sexual behaviours and increased the intention to remain abstinent in the IG, thereby reducing the incidence of early sexual initiation compared to the CG [45]. In two other studies, behavioural changes were observed, as the interventions led to increased attendance at sessions by IG participants, resulting in a slight reduction in STI rates compared to the CG [46,48].

A total of 33.33% of the studies identified multiple sexual partners as a risk behaviour among adolescents [26,28,29,35–37,46,48]. Of this, six studies reported changes in attitudes, with the interventions reducing the number of sexual partners in the IG compared to the CG [26,29,35–37,48].

One study observed an improvement in attitudes, reporting that communication about sexual health between parents and adolescents improved in the IG during the follow-up period after the intervention compared to the CG [47]. In contrast, another study reported a behavioural change, where the implemented intervention led to reduced rates of intimate partner violence in the IG compared to the CG [46].

Regarding the duration of intervention effects, twelve studies confirmed that the effects persisted for longer periods in the IG than in the CG [26,28,34–38,41,42,44,46,47]. However, one study noted that these effects gradually diminished over time in the IG, eventually eliminating the differences with the CG [49].

4. Discussion

From the studies selected in the review, we can notice some differences regarding the characteristics of the samples. In terms of the adolescents' age, most of the studies included participants in the age range of 14 to 16 years, placing them in the middle stage [25–30,34–38,40]; however, we also found adolescents in other stages within our sample [44–49]. These findings are consistent with other authors external to this review, who classified adolescence into early, middle, and late stages, showing that risky behaviours tend to initiate and can be found predominantly in the middle stage [6].

Regarding gender, most of the studies had samples predominantly consisting of females [25,26,28,29,32,33,40,45–47]. This contrasts with several authors external to this review, who demonstrated that males are more likely to engage in higher-risk sexual behaviours, although they are less involved in behaviour change [50]. Education is one of the key strategies for achieving significant progress in equality and responsibility for girls and women. Consequently, a transformation of the educational system is required, fostering greater participation of girls and women in research as well as in educational and cultural decision-making processes [5].

Myths surrounding fertility and contraception are widespread in adolescent sexuality, and addressing these misconceptions can lead to positive behavioural changes [29]. Therefore, a rights-based approach to CSE is essential, encompassing the physical, emotional, and

social dimensions of sexuality. However, cultural sensitivities regarding discussions about sex often hinder the effective inclusion of these aspects in educational programmes [30].

Among the findings of this review, various risky sexual behaviours have been detected in the adolescent population, namely: non-condom use and early sexarche. In relation to the risky behaviour of not using condoms, some studies linked this to socio-cultural inequality and gender, limited knowledge, and difficulty accessing resources due to economic challenges [25,32,39,41,47,49]. This is in line with several authors external to this review who presented sociocultural, gender, economic, and infrastructure-related barriers as well as limited knowledge as reasons for non-condom use [51,52]; however, we also found other external authors who described non-condom use in sexual relations between men who have sex with men as due to sociocultural, age-related, and economic barriers in addition to dissemination of unprotected sexual relations through pornography [53].

Regarding early sexarche, one study indicated that lack of sexual education contributes to this risky sexual behaviour due to lack of knowledge [45]. These findings are in line with other authors external to the review, who considered limited sexual knowledge as a reason for early sexual debut. Additionally, factors related to family structure and online activities such as sexting and pornography should be considered, as they promote such behaviours [54]. In cases where multiple risky behaviours arise simultaneously, three studies mentioned the lack of knowledge and limited sexual education provided in schools [35,36,48]. Various authors external to the review pointed out that the absence of sex education and family-related factors such as moderately functional and dysfunctional extended families promote greater risks in terms of number of sex partners, early sexarche, and non-condom use [55].

Regarding the contents included in the interventions, most studies focused on preventing unintended pregnancies through condom use [25,32–34,38–40,43,44,49]. These findings are in line with other authors external to this review, who asserted that non-condom use is a risk factor for HIV/STI infections and unwanted pregnancies [56].

As for the techniques employed, slightly more than half of the studies presented CSE through classes and activities [27–29,31,34–39,41,42,44,47]. These findings are in agreement with different authors external to the review that resorted to lectures and several activities related to debates, brainstorming, role-play games, and/or skills practice as more adequate learning techniques [57,58].

As for the place where they were conducted, most of the interventions were conducted in schools [25–32,34,35,37,40,44–46,48,49]. This contrasts with various external authors to the review, who argued that conducting interventions in schools promotes an environment with high levels of stress due to being part of a strict and regulatory system; conversely, conducting interventions in alternative locations encourages greater participation and effectiveness [59]. Additionally, other authors external to this review also supported conducting interventions in the school setting to collaborate with the teaching staff [60].

Referring to the delivered intervention content, the majority of studies delivered it in person [25–29,31–41,44–47,49]. Given these findings, different authors external to the review agreed with most of our studies by developing their interventions and/or sessions in the in-person modality [61–64]; however, we also found other external authors who noticed positive effects after implementing their interventions through social networks, namely Facebook, obtaining similar results to those achieved with the in-person modality in others [65]. Regarding the people in charge of conducting the interventions, in most of the studies, they were led by facilitators or health providers duly trained in the topic [27,29,33,37–41,44,47]. In this sense, an author external to the review opposed the aforementioned, indicating that school nurses should be considered, as they are the reference professionals

to deal with health topics at schools, therefore holding a privileged position for conducting training sessions in healthy sexuality [66].

Another of the findings we highlight in this review is related to the effectiveness we found in the CSE interventions conducted with adolescents. The vast majority of studies showed that there was an increase in knowledge, attitude, skills, and self-efficacy in condom use [26–32,34–36,38–44,46,47,49]. These findings are in line with a number of authors external to the review who were able to increase the self-efficacy levels for condom use among adolescents after implementing their theory-based “Usando Condón” (“Using Condoms”) intervention to prevent unwanted pregnancies and STIs [67]. In this sense, other authors pointed out that numerous factors act as barriers for adolescents accessing health services to obtain condoms or contraceptive methods, including costs and information about them [68].

In relation to unwanted pregnancy, almost one-third of the studies focused on its prevention [25,26,28,30,32–35,37–40,43,44,47,49]. Some authors external to the review indicated that it is necessary to foster sex education to promote a change in skills and attitudes among adolescents to prevent unwanted pregnancies, which is one of the main problems emerging among the girls that initiate their sexual activity [69].

Regarding HIV and other STIs, nearly 40% of the studies were targeted at preventing these infections [27,28,30,31,36,41,42,46–48]. In this sense, a number of authors external to the review pointed out that it is necessary for all people to receive sex guidance and education related to STIs, recommending encouraging education programs at schools [70]. Other authors also emphasized the use of pre-exposure prophylaxis (PrEP) as another effective and safe prevention strategy against HIV [71].

Regarding early sexual debut, there was a study where it was delayed through healthier behaviours and intention of abstinence [45]. These findings are in line with other authors who asserted that sex education allows delaying sexarche in adolescents [72]. Referring to multiple sex partners, in one-third of the studies, the number of sexual partners was reduced [26,28,29,35–37,46,48]. This is in agreement with some authors external to the review, who identified their interventions as effective in reducing the number of sex partners during adolescence [73].

One of the studies selected indicated that the IG was more effective in terms of knowledge and that it presented lower intimate partner violence (IPV) rates after the intervention, when compared to the CG [46]. This is in agreement with various authors external to the review who were able to reduce both the IPV rates and HIV incidence through the Safe Homes and Respect for Everyone (SHARE) Project [74]. Likewise, in another study, communication between adolescents and parents regarding sexual health was improved [47]. This latter aspect is in agreement with several authors external to the review, who included parents of adolescents in their programs with the objective of increasing communication and knowledge about sexual health between them, noticing significant benefits after the interventions [75].

Limitations

The studies included in our review present certain limitations. Some authors indicated that the results of their studies cannot be generalised or are not representative of the sample [25–28,30–34,36,37,40–43,45–48]. Others noted that the data collected to evaluate the interventions were based on self-reported surveys [25,26,29–31,37,38,41,42,46,47]. With regard to STIs, most studies referred to HIV and other STIs without providing further details. Only a few studies mentioned specific infections such as gonorrhoea or chlamydia. Another limitation is that the majority of studies assessed the impact on participants' knowledge and not their risk behaviours.

As for the limitations of our review, one notable issue is the heterogeneity observed among the studies in terms of samples, study periods, and interventions conducted. Nevertheless, several authors regarded such heterogeneity as a valuable source of information for research, provided that it is addressed methodically [18], as was done in this review. Finally, another limitation is that the searches were restricted to the last 10 years. Studies conducted prior to 2013 were not included in order to ensure access to the most recent evidence.

5. Conclusions

Regarding the sample characteristics, most participants in the studies were in mid-adolescence, with ages ranging from 14 and 16 years, and there was a predominance of females. Concerning adolescents' risky sexual behaviours, the primary reasons identified were socio-cultural inequality, limited sexual knowledge, and restricted access to resources due to economic challenges. With respect to sexuality education interventions, the majority focused on preventing unintended pregnancies by promoting condom use, employing a combination of classes and in-person activities in classroom settings. The main facilitators were trained professionals designated for the interventions. Most programs demonstrated success in improving knowledge, attitudes, self-efficacy, and intentions related to condom use and HIV/STI prevention as well as in reducing the number of sexual partners, attributed to enhanced sexuality knowledge among adolescents. Few studies reported significant changes in adolescents' sexual behaviours, such as consistent condom use and abstinence, which led to reductions in unintended pregnancies and HIV or other STIs. Notably, only two programs failed to demonstrate effectiveness.

Supplementary Materials: The following supporting information can be downloaded at <https://www.mdpi.com/article/10.3390/sexes6010006/s1>. Table S1: Characteristics of the risk behaviours, interventions, and effectiveness of sex education found in the studies.

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