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An Evidence-based Response to the Public Debate on RSE in The Netherlands

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We offer the following input into the public debate that is occurring in The Netherlands about relationship and sexuality education (RSE) in schools. As scientists who have conducted numerous studies evaluating sex education programs in schools, we welcome this opportunity. A serious debate is needed, one that takes an honest look at the evidence rather than disparaging or misrepresenting the work of reputable professionals.

A letter from a group of four professionals, van Lunsen, et al., criticizes the efforts by *Civitas Christiana* (CC) to question the sex education curriculum in The Netherlands. The core issue for the van Lunsen group appears to be a concern that CC has based its criticism of RSE on a research review by *The Institute for Research and Evaluation* (IRE) that was published in 2019 in a peer-reviewed academic journal.[1] The van Lunsen letter declares that this IRE review is "unscientific and unsound, with the authors selectively using pseudo-evidence to confirm their biased conclusions, while ignoring extensive and scientifically sound evidence to the contrary." They cite a critique by personnel at the World Health Organization as evidence for these claims. The following is a response by IRE to these criticisms.

1. *The Institute for Research and Evaluation* is an internationally respected scientific agency.

IRE is a non-profit scientific entity founded in 1986 specializing in the evaluation of interventions designed to reduce and prevent adolescent risk behavior. IRE has been evaluating sex education programs in schools for more than 35 years—involving more than 100 evaluation studies and 2,000,000 teens, including studies in 30 U.S. states (many federally funded) and several international countries. IRE research papers have been published in peer-reviewed journals, including, *The American Journal of Preventive Medicine*, *The American Journal of Health Behavior, Issues in Law and Medicine, Journal of Applied Psychology, Adolescence,* and *The Journal of Research and Development in Education.*

Stan E. Weed, Ph.D., Founder and Director, has been a national consultant for U.S. federal Title XX and CBAE projects; a charter member of the *National Campaign to Prevent Teen and Unplanned Pregnancy* (now called *Power to Decide*); has been invited to provide expert testimony on sex education to U.S. state legislative bodies, the *U.S. Senate*, the *U.S. House of Representatives,* and the *White House*; and has been a consultant to the *U.S. Department of Health & Human Services* (2018).

Irene H. Ericksen, M.S., Senior Research Associate, has spent 20 years in the field of sex education research; was one of six national consultants to a landmark CDC sponsored meta-analysis on sex education effectiveness (2012); has been an invited presenter at the *National Academies of Sciences* (2019), *United Nations Civil Society Conference* (2019), and *U.S. Department of Health & Human Services* (2020); and has testified as an invited expert in U.S. state legislative hearings (2023) as well as state and international court cases (2022, 2026).

2. The publication of the WHO critique of IRE research raises question about its motivation.

Instead of being published in a neutral academic journal, the WHO's critique is found in the publication of an advocacy organization, *Sexual and Reproductive Health Matters*, self-described as "a community of researchers, activists and other experts" working "to shift ideology and power-driven politics… towards human rights and social justice …[with] explicit attention to sexual and reproductive justice" (see https://www.srhm.org/about-us/).[2] The van Lunsen assertion that the IRE review is driven by "ideological positions" appears to be instead, applicable to the WHO's critique of IRE's research.

3. The IRE review utilized a scientific definition of sex education effectiveness to evaluate Comprehensive Sex Education (CSE) in school populations.

IRE identified studies of school-based CSE within 3 databases (103 studies in total, see Endnote 3 below for sources) and examined the studies' findings according to a scientific definition of program effectiveness. This definition was based on the scientific field of prevention research, including the work of agencies like *The Society for Prevention Research* (SPR) and *Blueprints for Healthy Youth Development*. The criteria for this definition are that an effective CSE program must produce a significant positive 12-month post-program effect on the target population (not just a subgroup), for one of the key protective behavior-based outcomes (abstinence, condom use, pregnancy, or STIs—the scientific justification for these outcomes was given in the IRE publication), and without producing other negative effects on teen risk behavior (this requirement is specified by both SPR and Blueprints).[4] This definition has both scientific credibility and practical utility. For example, a school-based RSE program targeting a specific school grade or age group should have a positive behavioral impact across that grade or age group not just a subset of it, the effect should last from one school year to the next (i.e., 12 months) when another "dose" can be received, it should improve behaviors that are truly protective, and it should not increase other risk behaviors.

The use of this rigorous, scientific definition of program effectiveness is one of the main reasons the IRE findings "differ so significantly from many other studies." Most mainstream messaging that declares CSE is effective employs an ineffectual, non-scientific set of criteria to define program success: short-term results (lasting only 3 months), effects for only a subgroup of the targeted population, no effects on key protective outcomes targeted by the program, and the occurrence of other negative program outcomes is acceptable. This definition of program effectiveness is not grounded in science and is not adequate to provide adolescents with real protection. Yet it forms the basis of the so-called "extensive and scientifically sound evidence to the contrary" referred to in the van Lunsen letter. For example, CSE programs meeting these low standards were placed on the Teen Pregnancy Prevention website's list of "programs showing evidence of effectiveness" by the U.S. Department of Health and Human Services during the Obama and Biden administrations.

4. WHO's re-analysis of CSE outcome data actually reports results similar to IRE's original findings: little evidence of effectiveness and a concerning amount of harmful impact.

Using the scientific definition of program effectiveness employed by IRE (see above), WHO reviewers analyzed the non-USA studies in the IRE review, and they found similar results.[2]

a. WHO reported that just 6 out of the 43 international studies showed evidence of effectiveness for school-based CSE, only 3 more than IRE reported. IRE disagrees that there are 6 such studies; WHO reviewers made several errors interpreting study results. For example, in one case, they called a subgroup effect an overall effect,[5] in another they gave credit for a 12-month post-program effect where none was indicated,[6] and in another case, counted a program as effective that had produced multiple negative effects on program participants.[7] However, notwithstanding these errors, it is confirmatory that WHO, like IRE, still found only a small minority of studies showing program effectiveness: only 13.9% according to WHO.

b. WHO also documented that 8 studies showed harmful program impact, that is, increases in teen risk behavior (correcting for an error in which WHO reviewers reported a negative statistical outcome, but mislabeled it as a positive/desired effect, see Endnote 8). The 8 studies with negative effects reported by WHO (19%) compares to the 9 (21%) reported by IRE.

Thus, the WHO critique was confirmatory of the overall IRE conclusion of little evidence of real effectiveness for CSE in schools, as well as confirming the claims made by *Civitas Christiana* that CSE programs in schools have had a concerning amount of negative impact**.**

5. WHO's critique of the IRE review contains a high level of factual error, negating its validity.

IRE meticulously reviewed the WHO critique and found a 56% error rate in its interpretation of scientific data as well as blatant errors in its representation of IRE's purpose and methods.

a. The WHO critique claims there are 66 instances of "discrepancies" between the findings reported in the IRE data table and the findings of the 43 studies IRE reviewed.[2] IRE analysts have carefully examined each of these claims compared to the text and data from each of the relevant original studies as well as the corresponding entries in IRE's data table. IRE found that the claimed discrepancies could be verified in just 9 of the 66 instances, none of which changed the overall results or conclusions of the IRE analysis.[9] Most concerning, 37 of the purported IRE discrepancies were actually errors by the WHO reviewers, based on mistaken interpretations of study data; 37 errors out of 66 discrepancy claims is a 56% rate of error for the WHO. (An example of one such error by the WHO reviewers is described in Endnote 8.) IRE's detailed analysis of the WHO errors is available in table form at https://institute-research.com/wp-content/uploads/2024/05/IRE_Review_of_WHO_Table_B1_Discrepancies5-20-24.pdf.
b. The WHO critique made many factually incorrect statements about the IRE methodology, creating a false picture that it was "poor science." For example, it claims that IRE's "designation of indicators as key protective indicators vs. less protective indicators" was not explained. This is a clear misstatement of fact. The IRE report gave a detailed review (p. 6) of the scientific rationale for *condom use* and *abstinence* as "key protective indicators" (*pregnancy* and *STIs* are self-evident).[1] And Endnote 20 in the IRE report (cited on p. 5, where key indicators were first named in the text) gave a detailed scientific rationale for the designation of "less-protective indicators."

6. The WHO employed a double standard in its critique of the IRE report.

For example, IRE was criticized for relying on UNESCO's screening for study quality and not conducting its own assessment of the scientific quality of included studies. (The rationale for this was explained by IRE as wanting to evaluate the studies that *UNESCO* deemed scientifically adequate.) However, at the same time, the WHO reviewers gave high praise to a review of research by Goldfarb and Lieberman (2021) for its "validity and rigour," even though *its authors conducted no screening whatsoever for the scientific quality of the 80 studies included in their review*.[10] Goldfarb and Lieberman actually acknowledged the "substantial number of studies with less rigorous designs, smaller samples, and/or more qualitatively based [i.e., subjective] approaches" (p.4) that they included. But the WHO reviewers were not deterred by the extreme lack of rigor in a study that they approved of.

7. Since 2018, 15 systematic reviews have shown little evidence of CSE effectiveness.

IRE examined 15 systematic reviews conducted since 2018, identifying the studies of school-based CSE included in each one, and evaluating their program outcomes using a scientific definition of sex education effectiveness (see item 3 above).[11] They found only 6 out of roughly 234 included studies showed evidence of program effectiveness. And none of the 6 were new evidence, that is, studies not already included in IRE's 2019 research review. A table documenting this analysis is attached.

15 Systematic Reviews of Sex Education Outcomes: 2018 - 2025	Included studies	Studies of school-based CSE (SBCSE)	SBCSE showing effectiveness[a]	New evidence for SBCSE effectiveness?
Marseille, 2018	21	13	1	NO
Mirzazadeh, 2018	9	4	1	NO
Morales, 2018[b]	63	55	0	NO
Koruk, 2019	13	5	0	NO
Evans, 2020	29	5	0	NO
Akmala, 2021[b]	12	8	2	NO
Loureiro, 2021	56	14	1	NO
Goldfarb, 2021	88	16	0	NO
Bordogna, 2021/3	29	11	0	NO
Juras, 2022	52	25	0	NO
Kim, 2023[b]	34	11	0	NO
Barriuso-Ortega, 2024[b]	47	20	0	NO
Niland, 2024[b]	27	25	0	NO
Pivazyan, 2025[b]	9	9	1	NO
Sierra-Yague, 2025	14	13	0	NO

a. In a scientifically credible study, the program produced a significant reduction in teen sexual risk behavior (increased condom use, or reduced sexual activity/ pregnancy/STDs) for the targeted youth population, that lasted at least 12 months post-program, without also showing negative effects in other studies.
b. Both USA and Non-USA studies were included.

8. Haberland, 2015, does not provide scientific support for school-based CSE/RSE.

The critics of *Civitas Christiana* cite research by Haberland (2015), who conducted a systematic review of evaluation studies.[12] However, only 10 of the 22 included studies reviewed by Haberland are school-based CSE, and therefore relevant to this debate. And none of these 10 studies show evidence of CSE effectiveness when scientific criteria for program effectiveness are used (see item 3 above). Moreover, 4 of the 22 studies showed negative programs effects: decreased contraceptive use (Kirby et al., 1997), increased sexual onset and number of partners (Dupas, 2011), an increase in paid sex (Jewkes, et al., 2008), and increased STIs (Ross, et al., 2007). (These negative impacts are not reported in the study Abstracts, but only in the Results section of each study.) In addition, two other studies in the Haberland review are of programs (*Reducing the Risk* and *Teen Outreach Program*) that have shown negative results in other published studies.[13] Thus, the Haberland review shows little evidence of school-based CSE effectiveness and points to substantial evidence of harmful CSE/RSE program impact (a total of 6 out of 22 programs).

9. A pattern of results

The study findings reported in IRE's 2019 research review, along with those cited above, show a consistent pattern of results over more than 30 years of CSE/RSE implementation in school classrooms worldwide. There is very little evidence of sustained protective behavioral impact and more evidence of harmful impact than is acknowledged by CSE advocates, when the outcomes of experimental studies (which are required to test causal impact) are employed.[14]

10. Conclusion

Civitas Christiana is completely justified in relying on the 2019 IRE review of research published in the journal, *Issues in Law and Medicine,* as well as the updated research results given in this document. We stand by those results. For details on these findings, see the attached IRE rebuttal to the WHO's critique, the attached table of systematic reviews, and this link for a table showing IRE's detailed analysis of the scientific errors found in the WHO critique: https://institute-research.com/wp-content/uploads/2024/05/IRE_Review_of_WHO_Table_B1_Discrepancies5-20-24.pdf.

11. Recommendations

We invite the critics of *Civitas Christiana* to identify school-based CSE/RSE programs that meet this scientific definition of effectiveness, based on evidence provided by peer-reviewed published experimental design studies. There will need to be a number sufficient to counteract the broad-based pattern of evidence identified here by IRE. We further recommend that the federal government of The Netherlands commission an experimental design study with a 12-month follow-up measure to evaluate the effectiveness of the RSE programming in the nation's schools. Such as study should be conducted by independent scientists who do not have a stake in the outcome and should employ the scientific definition of effectiveness described in section 3 above.

Endnotes

1. Ericksen, I.H. and Weed, S.E. (2019). "Re-Examining the Evidence for School-based Comprehensive Sex Education: A Global Research Review." *Issues in Law and Medicine, 34(2):161-182.*
2. VanTreeck K, Elnakib S, & Chandra-Mouli V. (2023) A reanalysis of the Institute for Research and Evaluation report that challenges non-US, school-based comprehensive sexuality education evidence base. *Sexual and Reproductive Health Matters*, 31:1, 2237791, DOI: 10.1080/26410397.2023.2237791
3. The IRE review examined the studies endorsed by three authoritative agencies: the CDC's meta-analysis of sex education (2012), the U.S. Teen Pregnancy Prevention Evidence Review (the TPP 2016 update) and the UNESCO 2018 *Technical Guidance on Sexuality Education*. Each of these agencies had endorsed CSE as an effective sex education strategy, based on its review of the research evidence. IRE's purpose was to examine and report on that evidence base, a total of 103 studies of school-based CSE. In the case of UNESCO 2018, these studies are listed on p. 129: "Appendix V. Studies referenced as part of the evidence review 2016." It states on this page that "Those [citations] marked with * were included in the analysis of systematic reviews and high-quality valuations." IRE included the studies marked with * and, where that study was a systematic review, also included the individual studies cited in that review, since they formed the basis for the systematic review's findings.
4. These standards or criteria for effectiveness are grounded in the work of the scientific field of prevention research, especially *The Society for Prevention Research* and *Blueprints for Healthy Youth Development*. See the work of: Flay BR, Biglan A, Boruch RF, Castro FG, Gottfredson D. (2005). Standards of Evidence: Criteria for Efficacy, Effectiveness and Dissemination. *Prev Sci*, 6(3):151–175; Gottredson DC, Cook TD, Gardner FEM, Gorman-Smith D, Howe GW, Sandler IN, Zafft KM. (2015). Standards of Evidence for Efficacy, Effectiveness, and Scale-up Research in Prevention Science: Next Generation. *Prev Sci*, 16(7):893-926. doi: 10.1007/s11121-015-0555-x; Blueprints for Healthy Youth Development: Blueprints Standards. Available at: https://www.blueprintsprograms.org/blueprints-standards/
5. Mathews C, Aarø LE, Grimsrud A, Flisher AJ, et al. (2012—listed as 2010 in IRE report). Effects of the SATZ teacher-led school HIV prevention programmes on adolescent sexual behaviour: cluster randomised controlled trials in three sub-Saharan African sites. *International Health*, (4) 111– 122, Site 3. When males and females were analyzed separately (p.117, Supplementary Tables 3 & 4), the effect was found only for males and not females. Thus, it became clear that it was a subgroup effect.
6. Dente, M, Fabiani, M, Okwey, R, Conestà, N, et al. (2005). Impact of Voluntary Counselling and Testing and Health Education on HIV Prevention among Secondary School Students in Northern Uganda. *VCT AND HEALTH EDUCATION FOR HIV PREVENTION*; 3 (1) 1 – 11. Page 2 says it was "a post-test only control group study." There was no indication that a long-term (12-month) post-program effect was measured.
7. Visser M. (2007). HIV/AIDS prevention through peer education and support in secondary schools in South Africa, SAHARA-J: *Journal of Social Aspects of HIV/AIDS*,4:3, 678-694, DOI: 10.1080/17290376.2007.9724891. The program increased teens' number of sex partners and the incidence of forced intercourse.

8. The WHO reviewers stated that 7 studies showed negative program impact. However, for one additional study that found a negative program effect, the WHO critique reported the negative statistical outcome correctly but then incorrectly labeled it as a positive/desired effect. (See Merakou K, Kourea-Kremastinou J. (2006). Peer education in HIV prevention: an evaluation in schools. *European Journal of Public Health*, Vol. 16, No. 2, 128–132. On p.131 the study states, "more students from the intervention group initiated sex." The number of virgin students decreased significantly in the intervention group, p<.001, but not in the control group, p<.064. This was an undesired program effect, and labeled as such by the study authors.) Based on the WHO's correct reporting of this negative statistical outcome, and correcting for their inarguable error in labeling it as desirable, the WHO analysis documented 8 CSE studies (19%) showing harmful program effects. The WHO claimed that IRE made an error in interpreting this outcome as negative, when their own misinterpretation is itself a very basic error in interpreting the study results.
9. The Institute for Research & Evaluation. (2024). *Rebuttal to a Critique by the World Health Organization.* October 15, 2024, Revised. https://institute-research.com/wp-content/uploads/2024/05/Rebuttal_to_WHO_Critique_of_IRE_Global_CSE_Review_5-20-24.pdf
10. Goldfarb E and Lieberman L. (2021). Three Decades of Research: The Case for Comprehensive Sex Education. *J Adolesc Health*, 68(1):13-27. doi: 10.1016/j.jadohealth.2020.07.036
11. Akmala JK, Pamungkasari EP, Prasetya H (2021). Meta Analysis of the Effect of School-Based Sexual Education on the Risk of Pregnancy and Human Immunodeficiency Virus Infection in Adolescents. *J Health Promote Behav*, 06(01): 67-79; BarriusoOrtega S, Fernandez-Hawrylak M, Heras-Sevilla D. (2024). Sex education in adolescence: A systematic review of programmes and meta-analysis. *Children and Youth Services Review*, 166 (2024) 107926; Bordogna A, Coyle, AC, Nallamothu R, Manko AL, Yen RW. (2023). Comprehensive sexuality education to reduce pregnancy and STIs in adolescents in the United States: A systematic review and meta-analysis. *American Journal of Sexuality Education*, v18 n1 p39-83; Evans, R., Widman, L., Stokes, M. N., Javidi, H., Hope, E. C., & Brasileiro, J. (2020). Association of Sexual Health Interventions With Sexual Health Outcomes in Black Adolescents: A Systematic Review and Meta-analysis. JAMA pediatrics, 174(7), 676–689; Goldfarb E and Lieberman L. (2021). Three Decades of Research: The Case for Comprehensive Sex Education. *J Adolesc Health*, 68(1):13-27; Juras, R., Kelsey, M., Steinka-Fry, K., Lipsey, M., Layzer, J., & Tanner-Smith, E. (2022). Metaanalysis of federally funded adolescent pregnancy prevention program evaluations. *Prevention Science*, 23(7), 1169-1195; Kim, E.J., Park, B., Kim, S.K., Park,,M.J., Lee, J.Y., Jo, A.R., Kim, M.J., Shin, H.N. (2023). A Meta-Analysis of the Effects of Comprehensive Sexuality Education Programs on Children and Adolescents. *Healthcare*, 11, 2511; Körük, S., Aypay, A., Salimoğlu, K. B., & Yılmaz-Din., S. (2019). An Examination of the Effectiveness of Various Intervention Programs in Increasing Sexual Health Knowledge and Behaviors in Adolescents: A Meta-analysis. *Bartın University Journal of Faculty of Education*, 8(1), 299-321; Loureiro, F., Ferreira, M., Sarreira-de-Oliveira P., Antunes, V. (2021). Interventions to Promote a Healthy Sexuality among School Adolescents: A Scoping Review. *J. Pers. Med*, 11, 1155; Marseille E, et al. (2018). Effectiveness of school-based teen pregnancy prevention programs in the USA: a systematic review and meta-analysis, *Prevention Science*, 19(4):468–489 prevention programs in the USA: a systematic review and meta-analysis, *Prevention Science*, 19(4):468–489; Mirzazadeh A, Biggs MA, Viitanen A, Horvath H, Wang LY, Dunville R, et al. (2018). Do School-Based Programs Prevent HIV and Other Sexually Transmitted Infections in Adolescents? A Systematic Review and Meta-analysis. *Prev Sci*, DOI 10.1007/s11121-017-0830-0; Morales A, Espada JP, Orgilés M, Escribano S, Johnson BT, Lightfoot M (2018). Interventions to reduce risk for sexually transmitted infections in adolescents: A meta-analysis of trials, 2008-2016. PLoS ONE 13(6):0199-421; Niland R , Flinn C, Nearchou F. (2024). Assessing the role of school-based sex education in sexual health behaviours: a systematic review. *Cogent Psychology*, VOL. 11, NO. 1, 2309752; Pivazyan L, Avetisyan J, Krylova E, Davydova Y, Kurbatova K, Zarova E. (2025). Sexual education and adolescents: a systematic review and meta-analysis. *Italian Journal of Gynaecology and Obstetrics*, DOI:10.36129/jog.2025.228; Sierra-Yague A, Zafra-Agea JA, Aguilar-Quesada A, Gonzalez-Cano-Caballero M, Del-Pino-Casado R, Lima-Serrano M. (2025). A Systematic Review and Meta-analysis of Gamified Affective Sexual Health Interventions in Schools. *Sexuality Research and Social Policy*, https://doi.org/10.1007/s13178-025-01118-3
12. Haberland, N. (2015). The case for addressing gender and power in sexuality and HIV education: A comprehensive review of evaluation studies. *International Perspectives on Sexual and Reproductive Health*, Vol. 41, No. 1, pp. 31-42.
13. Kelsey M, Blocklin M, Price C, Juras R, Freiman L, et al. (2016). Replicating Reducing the Risk: 12-Month Impacts of a Cluster Randomized Controlled Trial. *American Journal of Public Health, 106*(S1), S45–S52; Abt and Associates. (2018). Reducing the Risk: Impact findings from the Teen Pregnancy Prevention Replication Study (Research Brief and Impact Evaluation Findings), November 5, 2018. U.S. Department of Health and Human Services. Retrieved from https://aspe.hhs. gov/pdf-report/reducing-risk-impacts-teen-pregnancy-prevention-replication-study-research-brief; Philliber AE, Philliber S, Brown S. (2015). Evaluation of the Teen Outreach Program® in The Pacific Northwest. Accord, NY: *Philliber Research & Evaluation.* See: https://tppevidencereview.aspe.hhs.gov/StudyDetails.aspx?id=529; Walsh-Buhi ER, Marhekfa SL, Wang W, et al. (2016) The impact of the Teen Outreach Program on sexual intentions and behaviors. *Journal of Adolescent Health* 59: 283–290.
14. Advocates for CSE will sometimes claim to show evidence of positive impact using correlational/cross-sectional studies, which cannot scientifically identify cause and effect or the direction of a statistical correlational relationship and thus, cannot measure CSE program impact.