



Spotlight

School-based relationships and sexuality education (RSE): lessons for policy and practice

Dr. Ann Nolan, Senior Parliamentary Researcher (Social Science)

Abstract

There is clear evidence that school-based sex education programmes can improve sexual health outcomes. Women who have experienced sex education in schools are less likely to have experienced rape, abortion or distress about sex. Many factors combine to affect health and sex education will not override the determinants of health in general. The aim of this *Spotlight* is to consider the national and international policy architecture for school-based sex education, which favours a liberal and comprehensive approach, and to review current provision for sex education in post-primary schools in Ireland. The *Spotlight* will critique Ireland's historical relationship with sex education and conduct a rapid evidence assessment of good practice guidance for sex education programming in the liberal tradition generally favoured by European democracies.



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Summary

The United Nations Educational, Scientific and Cultural Organisation (UNESCO) and the World Health Organisation (WHO) claim that sexuality education leads to improved sexual and reproductive health outcomes, including a reduction in sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV) and unintended pregnancy.¹ Women who have experienced sex education in schools are less likely to have experienced rape, abortion or distress about sex.² Contrary to widely expressed fears, international evidence appears to suggest that sex education does not promote early sexual initiation but rather can delay sexual debut³ and increase condom use.⁴

However, these findings are not universally accepted because sex education is not an unambiguous, value-neutral concept, but one that is contested. The enduring 'problem' of sex education in every jurisdiction is that it is underpinned by diametrically opposed philosophical positions and even in countries where sex education is widely supported in principle, the content is frequently contentious.

Sex education programmes alone will not offset other factors that have profound impacts on young people's sexual, reproductive and other health outcomes. Many factors combine to affect health and as such, sex education is unlikely to override - without other supports and services – the determinants of health in general.

The aim of this *Spotlight* is to consider the national and international policy architecture for school-based sex education, which favours a liberal and morally relativist⁵ approach. It will review current provision for sex education in post-primary schools in Ireland and conduct a rapid evidence assessment of good practice guidance for sex education programming in the liberal tradition generally favoured by European democracies.

The Policy Context

One nationally representative and internationally comparable study on young people's (15-18 years)⁶ sexual behaviours reported that over 25% of boys and 21% of girls had experienced sexual intercourse but most of these became sexually active in the 17-18 age range.⁷ Very early sexual initiation (e.g. 14+ years) and higher levels of risk-taking were found to be associated with alcohol, tobacco and cannabis involvement in boys and girls. This corresponds with international research, pointing to clear links between substance use and early sexual initiation. While the evidence is inconclusive, young Travellers and boys from lower socio-economic groups also appear to be at increased risk of poorer sexual health outcomes. Girls from lower income families in Ireland are more likely to have been sexually active from a young age than those from higher socio-economic groups.

This study also found that being bullied in school is associated with very early sexual initiation, which when combined with the findings from the *LGBTIreland* report, suggests that Lesbian Gay, Bisexual, Transgender and Intersex (LGBTI – see Appendix B for definitions) young people are at particular risk of poorer sexual health outcomes across the lifecycle. This is further reinforced by

¹ UNESCO, *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review* (Paris: France, 2015); WHO. Defining sexual health. Report of a technical consultation on sexual health 28-31 January 2002. Geneva: WHO; 2006

² Pound et al, 2016: 4

³ First sexual experience

⁴ Fonner et al. School based sex education and HIV prevention in low and middle-income countries: A systematic review and meta-analysis. (2009) PLoS ONE 9(3): e89692. Doi: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0018321>
UNESCO. International Technical Guidance on Sexuality Education: An Evidence-informed approach for schools, teachers and health educators. Paris, UNESCO. 2009. <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>

⁵ This philosophical position suggests that there is no objectively determined measure of 'right' or 'wrong' and so the individual must decide what is morally 'right' or 'wrong' for him or her in sexual terms

⁶ Young H, Burke L, Nic Gabhainn S. *Sexual intercourse, age of initiation and contraception among adolescents in Ireland: findings from the Health Behaviour in School-aged Children (HBSC) Ireland study*. BMC Public Health. 2018;18:362. doi:10.1186/s12889-018-5217-z.

⁷ Ibid, 2018:6

data from the Health Protection Surveillance Centre (HPSC) which indicates that young men-who-have-sex-with-men (MSM) are most at risk of being diagnosed HIV positive in Ireland.⁸ Furthermore, the *LGBTIreland* study found that almost half of all participants aged 14-25 years had taken drugs recreationally, which increases the likelihood of sexual risk taking and very early sexual initiation.

The highest prevalence of Sexually Transmitted Infections (STIs) in Europe is among young adults (15-24 years) and MSM. There has been an increasing trend in STI notifications in Ireland since the 1990s and between 2016 and 2017, the number of STIs reported in the 15 - 24 year old age group increased by 11%.⁹ The number of people testing positive for HIV has also been increasing in Ireland since 2014.

The number of women travelling to the UK for an abortion has been declining since 2001 when 6,673 women with an address in the Republic of Ireland underwent the procedure. In 2017, 3,092 women living in Ireland had an abortion in the UK. Uptake of at-home medical termination of pregnancy may account for the exponential decline in the number of women accessing abortion but other factors – including the possibility of more effective family planning – may also be at play.

The Policy Architecture for School-based Sex Education

Young people's access to sexual and reproductive health information, education and services, is enshrined in international agreements signed by Ireland: from the [Programme of Action of the International Conference on Population and Development \(ICPD\)](#) in 1994, to the [Education 2030 Incheon Declaration](#) which sets out a new vision for education over the next fifteen years. Comprehensive sex education is further enshrined in the [2030 Agenda for Sustainable Development](#) with Sustainable Development Goal (SDG) 3 (Target 3.7) calling for access to sexual and reproductive health-care services, including information and education. As a United Nations member state, Ireland is obliged to comply with human rights, including the right to sexuality and reproductive health education, while the [National Sexual Health Strategy 2015-2020](#) stresses the importance of early exposure to quality sexuality education.

Historical Overview of Sex Education in Ireland

The sex education debate in Ireland, as internationally, has been philosophically and ideologically polarised. Throughout the 1970s and 1980s, some regional health authorities had attempted to provide sex education in various locations but efforts were piecemeal, inconsistent and uncoordinated. While calls for school-based sex education originated with concerns for crisis pregnancy in the 1970s, the fear surrounding AIDS in the 1980s mobilised political support. The *AIDS Education Resource* – which incorporated all the then recommended components of sex education - was officially introduced in post-primary and vocational schools throughout the country on 2nd October 1990. However, delivery was not mandatory and implementation was inconsistent. The *Expert Advisory Group on Relationships and Sexuality Education* - set up by then Minister for Education, Niamh Breathnach, T.D., in April 1994 - concluded that the school had a role to play in supporting and complementing the work of the home in sex education. Following the *Report of the Advisory Group on Relationships and Sexuality Education*, a National Co-ordinator for Relationships and Sexuality Education (RSE) was appointed in 1995 and *Interim Curriculum Guidelines for RSE as an aspect of Social Personal and Health Education (SPHE)* were developed by the *National Council for Curriculum Assessment* in 1996. RSE was implemented as a mandatory component of SPHE in Ireland in 1997: it was recommended that the core values and ethos of the school should be clearly articulated in the school policy, with due regard for the views of parents.

The Current RSE Programme in Ireland

⁸ Health Protection Surveillance Centre, [HIV Report, 2016](#). HSE, 2017: 4

⁹ Across all age categories, STI's increased by 10% between 2016 and 2017.

RSE is mandatory and must be provided to all students in both junior and senior cycles. A national survey of primary and post-primary teachers, parents and schools found overwhelming support for school-based sexuality education, with teachers reporting a high level of satisfaction with the training they had received. An independent review of RSE conducted a decade after its implementation found that while most schools were delivering RSE, there was significant variance in the quality of RSE delivery. The Department of Education and Skills Inspectorate (2013) also found significant variation in the quality of RSE provision. The programme has been criticised for the absence of explicit directives and teaching resources for specific and often sensitive topics, which, it is claimed, in practice means that students do not have equal opportunities for learning, discussion and debate on some aspects of sexuality. One survey of 13 to 24 year old LGBTI young people in 2017, for example, found that 39% complained of the absence of inclusive sex education in schools.

On 3rd April 2018, Minister for Education and Skills, Richard Bruton T.D., announced a review of the RSE curriculum.

Good Practice for Relationships and Sexuality Education

What works?



Programmes addressing gender or power are five times as likely to be effective in reducing crisis pregnancy and STIs

Young people engage better with a 'sex positive' approach: they want to learn about the risks but also the pleasures of sexuality

There is clear evidence that school-based sex education programmes are effective in improving sexual health outcomes

The most effective interventions are held in small groups, are multifaceted, interactive and involve a variety of activities

Well trained instructors are critical to a programme's success. The characteristics of the instructor affects young people's acceptance and engagement with the programme

Programmes that involve close liaison with sexual health services are particularly effective

Multicomponent interventions that link school-based sexuality education with non-school-based youth-friendly health services report better outcomes.

Important To Note



Abstinence-only programmes are not effective at promoting positive changes in sexual behaviour & young people report that they find abstinence approaches unrealistic

Discomfort is sometimes reported in mixed-sex classes emphasising the need for good class control to ensure a safe environment

There is an association between frequent use of violent pornography and sexually aggressive attitudes among adolescent boys

In excess of one third of students in an NUIG study exploring issues of consent who were not in a relationship (n=240) said they would find it difficult or very difficult to tell a partner that a particular sexual activity was not making them feel good

School-based sex education is not enough by itself to prevent HIV and ensure the health and rights of young people but it is a cost-effective strategy

Some LGBTI students report feeling invisible within sexuality & relationships education

Young people who report lessons at school as their main source of information about sex are less likely to have had unsafe sex in the past year than young people who report receiving most of their information about sex from other (non-parental) sources

Conclusion

Ireland's relationship with sexual knowledge has, throughout the twentieth century in particular, reflected the wider tensions that characterise the debate in other countries. The United Nations and the World Health Organisation situate sex education in a rights-based framework that emphasises adolescent sexuality as an important stage in the human lifecycle. While this view is far from universally accepted, European democracies – more recently including Ireland – are generally more closely aligned with the rights-based emphasis of the international policy architecture for school-based sex education. Evidence suggests that school-based sex education programmes can be effective in improving objective and reported sexual health outcomes¹⁰ and can reduce the likelihood of crisis pregnancy and abortion.¹¹ However, sex education programmes alone will not offset other factors that have profound impacts on young people's sexual and reproductive health.

¹⁰ Pound *et al*, 2016, 9; UNESCO, 2016.

¹¹ Pound *et al*, 2016: 4

1. Introduction

UNESCO and the World Health Organisation (WHO) claims that sexuality education leads to improved sexual and reproductive health outcomes, including a reduction in sexually transmitted infections (STIs), Human Immunodeficiency Virus (HIV) and unintended pregnancy.¹² A global review of evidence for relationships and sexuality education published by UNESCO in collaboration with the United Nations Population Fund (UNFPA) and the United Nations AIDS Programme (UNAIDS) Secretariat concluded that sexuality education improves knowledge and self-esteem, and can help to change attitudes and societal norms around gender and rights. Contrary to widely expressed fears, this evidence appears to suggest that sexuality education does not promote early sexual initiation but rather can delay sexual debut and increase condom use.¹³

However, these findings are not universally accepted because sex education is not an unambiguous, value-neutral concept, but one that is contested. For example, one study undertaken by health economists in the United Kingdom (UK) found that sex education programmes may encourage earlier and more frequent sexual activity,¹⁴ while two Cochrane Database Systematic Reviews¹⁵ of school-based interventions stopped short of deciding whether or not the evidence supports the effectiveness of school based sex education.^{16 17}

The enduring ‘problem’ of sex education in every jurisdiction is that it is underpinned by diametrically opposed philosophical positions: on one hand, sex education is delivered in a *morally relativist* way meaning that there is no objectively determined measure of ‘right’ or ‘wrong’ and so the individual must decide what is morally ‘right’ or ‘wrong’ for him or her in sexual terms. On the other hand, sex education is also understood in *morally absolutist* terms, which is based on the belief that there is always one right answer to any ethical question.

Within these two philosophical positions, there are also liberal and conservative philosophical perspectives at play: *Liberalism* is concerned with the freedom and equality of the individual, while *Conservatism* emphasises the retention of traditional institutions and values.

Ireland’s relationship with sex education has embraced both of these positions and perspectives: up to the 1990s, school-based sex education, if it was delivered at all, was largely informed by conservative *moral absolutism* and any attempt to liberalise this position was resisted as outlined in Chapter 4 of this *Spotlight*. Rising rates of crisis pregnancy, the threat posed by Acquired Immune Deficiency Virus (AIDS)¹⁸ and the increasing liberalisation of Irish society gradually provided the impetus for a shift towards a *morally relativist* approach to the regulation of sexuality including school-based sex education from the early 1990s.¹⁹ The outcome of the marriage equality referendum in 2015 and the referendum to repeal the 8th amendment to the Constitution of Ireland suggest that Ireland’s approach to school-based sex education is equally shifting towards a more liberal morally relativist model – see *Figure 1*. As submissions to the [Joint Committee on Education and Skills’ review of Relationships and Sexuality Education \(RSE\)](#) illustrate, however,

¹² UNESCO, *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review* (Paris: France, 2015); WHO. Defining sexual health. Report of a technical consultation on sexual health 28-31 January 2002. Geneva: WHO; 2006

¹³ Fonner *et al.* School based sex education and HIV prevention in low and middle-income countries: A systematic review and meta-analysis. (2009) PLoS ONE 9(3): e89692. Doi: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0008969>

UNESCO. 2009. International Technical Guidance on Sexuality Education: An Evidence-informed approach for schools, teachers and health educators. Paris, UNESCO. <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>

¹⁴ Paton, D., Wright, L., *The effect of spending cuts on teen pregnancy*, Journal of Health Economics, Volume 54, July 2017, Pages 135-146

¹⁵ Leading database for systematic reviews of evidence in health care

¹⁶ Lopez LM, Bernholm A, Chen M, Tolley EE. School-based interventions for improving contraceptive use in adolescents. Cochrane Database of Systematic Reviews 2016, Issue 6. Art. No.: CD012249. DOI: 10.1002/14651858.CD012249.

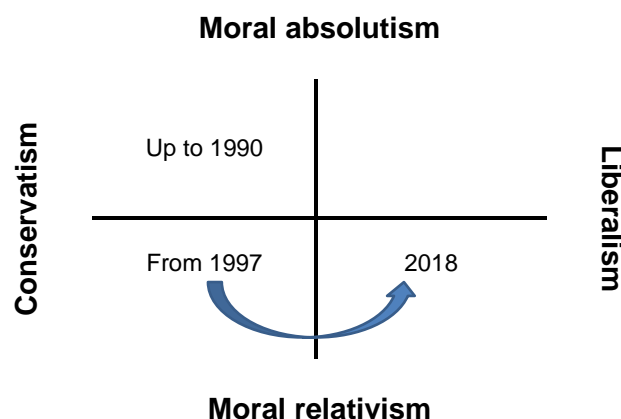
¹⁷ Amanda J Mason-Jones, David Sinclair, Catherine Mathews, Ashraf Kagee, Alex Hillman, Carl Lombard, School-based interventions for preventing HIV, sexually transmitted infections, and pregnancy in adolescents, Cochrane Database of Systematic Reviews, 2016

¹⁸ AIDS is a spectrum of conditions caused by infection with the Human Immunodeficiency Virus (HIV)

¹⁹ Nolan, A. The Gay Community Response to the Emergence of AIDS in Ireland: Activism, Covert Policy, and the Significance of an "Invisible Minority". Journal of Policy History 2018. 30(1), 105-127. Cambridge University Press. Retrieved August 28, 2018, from Project MUSE database; Nolan, A., The transformation of school-based sex education policy in the context of AIDS in Ireland, Irish Educational Studies, 2018. DOI: 0.1080/03323315.2018.1498234; Hug, C., The Politics of Sexual Morality in Ireland. Palgrave MacMillan. 1998; Ferriter, D., Occasions of Sin. Profile Books: 2009

both perspectives continue to be reflected in Irish society albeit that the conservative and *morally absolutist* approach appears to be in decline.

Figure 1: Ireland's Philosophical Approach to School-based Sex Education



While this *Spotlight* will consider Ireland's transition from a minimalist and morally absolutist conservative approach to school-based sex education, the time limitations of this review of the research evidence preclude interrogation of multiple perspectives. As such, the aim of this *Spotlight* is to consider the national and international policy architecture for school-based sex education, which favours a liberal and morally relativist approach. It will review current provision for sex education in post-primary schools in Ireland and conduct a rapid evidence assessment of good practice guidance for sex education programming in the liberal and morally relativist person-centred tradition generally favoured by European democracies (see below).

For a more detailed methodology, please refer to Appendix A.

1.1 What is school-based sex education?

UNESCO defines school-based sexuality education 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.*²⁰

School-based sexuality education is now implemented in a wide variety of both developed and developing countries.²¹ Three categories of programmes tend to be observed:

²⁰ UNESCO. International Technical Guidance on Sexuality Education: An Evidence-informed approach. Revised Edition. Paris, UNESCO. <http://unesdoc.unesco.org/images/0026/002607/260770e.pdf> (2018: 16)

²¹ UNESCO, International technical guidance on sexuality education. Vol. I – Rationale for sexuality education. Paris (<http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>). 2009.

1. **Abstinence-based programmes** are based on abstaining from sexual intercourse before marriage. Abstinence-based programmes have tended to be favoured by Republican administrations in the United States of America (USA), while their overseas development assistance programme has influenced the expansion of abstinence-based sex education in developing regions of the world;
2. **Comprehensive programmes** consider abstinence as one option among others including contraception and safer sex practices. Such programmes tend to be called ‘comprehensive sexuality education.’ Comprehensive programmes emerged as a reaction to abstinence only programmes. A significant number of studies have found that “abstinence only” programmes have no positive effects on sexual behaviour or the risk of teenage pregnancy, whereas comprehensive programmes have been shown to have a positive effect on rates of crisis pregnancy, Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs);²²
3. **Holistic sexuality education** includes elements of comprehensive sexuality education within a wider programme of personal and sexual growth and development.

In the USA, abstinence-based or comprehensive-type programmes are found. This is perhaps due to the complexity of religious and political geography in the United States, where high concentrations of religious belief shape the vast socio-political landscape. Such dichotomy of religious belief is less prevalent in European democracies. Since the 1970s there has been a growing acceptance that sexuality is not so much biologically determined as shaped by culture and values.²³ *for example*, polygamy and polyandry are accepted practices in some cultures but not in others. Child sexuality - previously perceived as immoral or even pathological – was by the latter half of the twentieth century, more likely to be viewed as a healthy and natural part of child development.²⁴ There has been a growing awareness in the 21st century that children are increasingly exposed to sexually explicit material, while paedophilia and the sexual abuse of children has prompted a Europe-wide debate about the need for holistic sexuality education.²⁵ The World Health Organisation (WHO) claims that sex education in Europe has, in general, tended to be personal-growth-oriented and sexuality, as it emerges and develops during adolescence, is less likely to be perceived as a threat²⁶, but as an important stage in the human lifecycle. This view is, however, far from universal: sexuality education is a widely contested area of policy making, not least because the sexuality of children and the very concept of sexual knowledge is neither unambiguous nor value-neutral.

For definitions of sex, sexuality, sexual health, sexual rights and other terms used throughout this *Spotlight*, please see Appendix B.

²² Kohler PK, Manhart LE, Lafferty WE, Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*. 2008; 42, 4:344-351; Carr, J., Packham, A., The effects of state-mandated abstinence-based sex education on teen health outcomes, *Health Econ*. 26: 403–420 (2017); UNESCO, Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education: A Global Review (Paris: France, 2015); UNESCO. Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO. (2016); Pound P, Denford S, Shucksmith J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. *BMJ Open* 2017;7:e014791. doi: 10.1136/bmjopen-2016-014791

²³ Foucault, M. *The History of Sexuality*, translated by R. Hurley, 3 vols, New York: Pantheon, 1978, 1985, 1986, in *Shaping Sexual Knowledge: A Cultural History of Sex Education in Twentieth Century Europe*. Ludz DH Sauerteig and Roger Davidson (Eds). Routledge: London and New York, 2009.

²⁴ *Shaping Sexual Knowledge: A Cultural History of Sex Education in Twentieth Century Europe*. Ludz DH Sauerteig and Roger Davidson (Eds). Routledge: London and New York, 2009: 2-3

²⁵ *Shaping Sexual Knowledge*, 2009: 4-5

²⁶ WHO Regional Office for Europe and BZgA, Standards for Sexuality Education in Europe: A framework for policy makers, educational and health authorities and specialists. (Cologne: 2010, p15)

2. The Policy Architecture for Sexuality Education

Chapter Summary

- Young people's access to sexual and reproductive health information, education and services, is enshrined in international agreements signed by Ireland:
 - Programme of Action of the International Conference on Population and Development (ICPD) in 1994;
 - Education 2030 Incheon Declaration;
 - 2030 Agenda for Sustainable Development;
 - United Nations Convention on the Rights of the Child, 1989;
 - United Nations Convention on the Rights of Persons with Disabilities (*ratified by Ireland in March 2018*).
- Ireland has a permanent delegation to the United Nations Educational Scientific and Cultural Organisation (UNESCO), which has developed an evidence-informed approach to technical guidance for sexuality education programming (2018);
- The World Health Organisation considers sexuality education an intrinsic component of population development and health promotion;
- The European Expert Group on Sexuality Education positions relationships and sexuality education in a rights based framework;
- As a United Nations member state, Ireland is obliged to comply with human rights, including the right to sexuality and reproductive health education;
- Ireland's *National Sexual Health Strategy 2015-2020* stresses the importance of early exposure to quality sexuality education;
- Article 42.1 of Bunreacht na hÉireann recognises parents as the primary educators of their children.

Young people's access to sexual and reproductive health information, education and services, is enshrined in international agreements signed by Ireland: from the [Programme of Action of the International Conference on Population and Development](#) (ICPD) in 1994, to the [Education 2030 Incheon Declaration](#) which sets out a new vision for education over the next fifteen years. Comprehensive sex education is further enshrined in the [2030 Agenda for Sustainable Development](#) with Sustainable Development Goal (SDG) 3 (Target 3.7) calling for access to sexual and reproductive health-care services, including information and education.

Ireland has a permanent delegation to the United Nations Educational Scientific and Cultural Organisation (UNESCO), which has developed [International technical guidance on sexuality education: An evidence-informed approach \(2018\)](#). This guidance is to assist education, health and other authorities in the development and implementation of school-based and out-of-school sexuality education programmes and is integrated with the wider SDG agenda. Furthermore, the World Health Organisation Regional Office for Europe and BZgA developed [Standards for Sexuality Education in Europe: A framework for policy makers, educational and health authorities and specialists](#) in 2010 in response to globalization and increased migration, the spread of HIV/AIDS and changing attitudes and sexual behaviour among young people.²⁷ This framework is rights-based and situates sexuality education as part of a more general programme of education that improves quality of life, overall health and wellbeing. In this way, the World Health Organisation considers sexuality education an intrinsic component of population development and health promotion.

[Policy Brief No. 1](#), produced by the European Expert Group on Sexuality Education positions relationships and sexuality education in a rights based framework:

²⁷ WHO Regional Office for Europe and BZgA, Standards for Sexuality Education in Europe: A framework for policy makers, educational and health authorities and specialists. (Cologne: 2010)

Good quality sexuality education is grounded in internationally accepted human rights, in particular the right to access appropriate health-related information. This right has been confirmed by the United Nations Convention on the Rights of the Child²⁸, the Committee on the Elimination of Discrimination against Women²⁹, the Committee on Economic, Social and Cultural Rights³⁰ and also in the United Nations Convention on the Rights of Persons with Disabilities³¹. Furthermore, sexuality education is advocated for in the 1994 Programme of Action of the International Conference on Population and Development³², and its importance has been underscored by the United Nations Special Rapporteur on the Right to Education in a 2010 report to the United Nations General Assembly devoted exclusively to this topic³³ and by the European Court of Human Rights in 2011.^{34 35}

As a United Nations member state, Ireland is obliged to comply with human rights, including the right to sexuality and reproductive health education. The Department of Education and Skills (DES) has been proactive in highlighting that the provision of sexuality education is a human rights obligation under the European Social Charter. Following the decision of the European Committee of Social Rights in the case of *Interrights v. Croatia*, which interpreted Article 11.2 of the Charter as requiring that health education be 'provided throughout the entire period of schooling', the DES issued a circular emphasising that sexuality education is defined as being "objective, based on contemporary scientific evidence and does not involve censoring, withholding or intentionally misrepresenting information."³⁶

Ireland's [National Sexual Health Strategy 2015-2020](#) reflects international standards and stresses the importance of early exposure to quality sexuality education that promotes,

²⁸ "Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity." (CRC/GC/2003/4, para 26)

²⁹ Committee on the Elimination of Discrimination against Women. General recommendation No. 28 on the core obligations of States parties under article 2 of the

Convention on the Elimination of All Forms of Discrimination against Women (<http://www2.ohchr.org/english/bodies/cedaw/comments.htm>). See also the Beijing Declaration and Platform for Action of the Fourth United Nations Conference on Women (Beijing, China, 1995, <http://www.un.org/womenwatch/daw/beijing/platform/>).

³⁰ The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as [...] access to health-related education and information, including on sexual and reproductive health." (Committee on Economic, Social and Cultural Rights, General Comment No. 14, para. 11, available from www.ohchr.org).

³¹ Article 25 – Health. United Nations Convention on the Rights of Persons with Disabilities. A/61/611, 6 December, 2006

³² The 1994 ICPD Programme of Action (paragraphs 4.29, 7.37, 7.41, 7.47) explicitly calls on governments to provide sexuality education to promote the well-being of adolescents and specifies key features of such education. It clarifies that such education should take place both in schools and at the community level, be age-appropriate, begin as early as possible, foster mature decision-making, and aim to advance gender equality. In addition, the Programme of Action urges governments and non-governmental organizations (NGOs) to ensure that such programmes address specific topics – including gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life, and STIs, HIV and AIDS prevention (http://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf)

³³ A/65/162, 2010. Report of the United Nations Special Rapporteur on the right to education: Sexual education. United Nations, 2010.

³⁴ Four families had lodged a complaint because they opposed mandatory sexuality education in Germany. The Court stated that the neutral transmission of knowledge is a prerequisite for developing one's own moral standpoint and reflecting society's influences in a critical way. The Court ruled in favour of Germany. European Court of Human Rights, 2011.

³⁵ UNFPA, WHO, BZgA, *Sexuality Education: Policy Brief 1*, BZgA, Cologne: 2016

³⁶ Department of Education and Skills. 2010b. Circular 0023/2010: Relationships and Sexuality Education. Dublin: Department of Education and Skills. <http://www.sphe.ie/downloads/Circulars/DES%20CIRCULAR-0023%20APRIL%202010.pdf> quoted in Wilentz. G., The importance of European standards and a human

rights-based approach in strengthening the implementation of sexuality education in Ireland, Sex Education, 2016: 16:4, 439-445, DOI: 10.1080/14681811.2016.1146988

...positive mental and physical wellbeing, as well as an individual's ability to develop appropriate competencies and skills, to avoid sexual exploitation and abuse and to achieve healthy sexual development.³⁷

Finally, however, policymakers and programme planners must take cognisance of provisions within Bunreacht na hÉireann that recognises the rights of parents as the primary educators of their children in Article 42.1:

The state acknowledges that the primary and natural educator of the child is the family and guarantees to respect the inalienable right and duty of parents to provide, according to their means, for the religious and moral, intellectual, physical and social education of their children.

³⁷ Department of Health, [National Sexual Health Strategy 2015-2020](#). (Dublin: 2015, p. 36)

3. The Policy Context

Chapter Summary

- Early sexual initiation (i.e., sexual initiation before 16 years old) has been associated with adverse sexual health outcomes and has implications for self-perception, well-being and a tendency to riskier sexual behaviours in adulthood;
- Male and female adolescents tend to express regret and report a higher risk of depression following early sexual debut;
- A study of 4,494 schoolchildren aged 15–18 years in Ireland demonstrated that in excess of 25% of boys and 21% of girls had experienced sexual intercourse but most of these reported that they first became sexually active in the older age range;
- Girls from lower income families were more likely to have been sexually initiated than those from other socio-economic groups;
- Very early sexual initiation (14-15 years) was reported more frequently by boys and girls from rural areas and the Travelling community;
- 80% of boys and girls who had said that they were sexually initiated, reported using condoms the last time they had intercourse and 20% of boys and 25% of girls reported using the contraceptive pill; 14% used withdrawal (i.e. practice of withdrawing the penis from the vagina before ejaculation), and 10% of boys and 6% of girls reported using no method of contraception at last intercourse;
- Alcohol, tobacco and cannabis were associated with sexual initiation among both boys and girls, and cannabis in particular was found to be associated with very early initiation for both boys and girls. Alcohol consumption was associated with very early sexual initiation among boys only;
- The *LGBTIreland* study reported that 49.9% of participants aged 14-25 years had taken drugs recreationally, increasing the likelihood of sexual risk taking and very early sexual initiation;
- Young LGBTI people are more likely to experience bullying in school which places them at particular risk of poorer sexual health outcomes;
- There has been an increasing trend in STI notifications in Ireland since the 1990s, which may be due to improvements in testing methods, improved access to testing and screening, more comprehensive surveillance, as well as ongoing unsafe sexual behaviours;
- Between 2016 and 2017, the number of STIs reported in the 15 - 24 year old age group increased by 11%;
- Of the 508 new diagnoses of HIV reported in 2016, sex between men was the predominant mode of HIV transmission (51%), followed by heterosexual transmission (28%), while 4% were among people who inject drugs (PWID). 25% (n=129) of new diagnoses in 2016 were born in Ireland and 61% (n=311) were born overseas (36% in sub-Saharan Africa and 33% in Latin America);
- The number of women travelling to the UK for an abortion has been declining since 2001: in 2017, 3,092 women living in Ireland had an abortion in the UK;
- 1,642 abortion pill packages were sent to Ireland in the 3 year period 2010 to 2012 by a single provider.

3.1 Overview

The World Health Organization (WHO) suggests that positive sexual health is important in terms of a person's physical and mental well-being and claims that it is also essential to the realisation of human rights, global health and sustainable development.³⁸ Early sexual initiation (i.e., sexual

³⁸ WHO. Defining sexual health. Report of a technical consultation on sexual health 28-31 January 2002. Geneva: WHO; 2006.

initiation before 16 years old) has been associated with adverse sexual health outcomes³⁹ and has implications for self-perception, well-being and a tendency to riskier sexual behaviours in adulthood.⁴⁰ Young people typically engage in experimental behaviours in the transition period to adulthood⁴¹ but physiologically, young girls aged 14 and younger are too young to have intercourse, while male and female adolescents tend to express regret and report a higher risk of depression following early sexual debut.⁴²

There is limited data on young people's sexual health behaviours in Ireland apart from some retrospective accounts of teenage behaviour⁴³ or small regional studies⁴⁴. [Young, Burke and Nic Gabhainn](#) recently conducted the first nationally representative and internationally comparable study on young people's sexual health behaviours in Ireland using self-complete questionnaires from 4,494 schoolchildren aged 15–18 years.⁴⁵ Over 25% of boys and 21% of girls reported that they had experienced sexual intercourse but most of these reported that they first became sexually active in the older age range.⁴⁶ Girls from lower income families were more likely to have been sexually initiated than those from other socio-economic groups. A similar pattern was observed among boys but the finding was not significant (i.e. the study did not find a relationship between male gender and higher levels of sexual initiation).

There were no differences in reported sexual initiation according to urban or rural residential status but the researchers found that boys and girls who lived with one parent were more likely to have experienced sexual initiation. Young Travellers reported that they were more likely to have experienced sex than non-Travellers but due to the small sample-size, this finding cannot be fully relied upon.⁴⁷ Young people were more likely to have had sex when alcohol, tobacco and cannabis were also involved. However, involvement with music and drama and living with both parents are protective factors for sexual initiation the study found.⁴⁸

Very early sexual initiation (14-15 years) was reported more frequently by boys and girls from rural areas and the Travelling community. However, the study found no particular relationship between very early sexual initiation and household income or composition.⁴⁹

Eighty per cent of boys and girls, who had said that they were sexually initiated, reported using condoms the last time they had intercourse, while 20% of boys and 25% of girls reported using the contraceptive pill. Condom use is therefore the most common method of contraception among young people, which is consistent with similar international studies⁵⁰. Fourteen per cent used withdrawal (i.e. practice of withdrawing the penis from the vagina before ejaculation), while 10% of

³⁹ Magnusson C, Trost K. Girls experiencing sexual intercourse early: could it play a part in reproductive health in middle adulthood? *J Psychosom Obstet Gynaecol*. 2006;27:237–44.

⁴⁰ Fergus S, Zimmerman M, Caldwell C. Sexual risk behaviour in adolescence and young adulthood. *Am J Public Health*. 2007;97:1096–101, 12; Magnusson B, Masho S, Lapane K. Early age at first intercourse and subsequent gaps in contraceptive use. *J Women's Health*. 2012;21:73–9.

⁴¹ Avery L, Lazdane G. What do we know about sexual and reproductive health of adolescents in Europe? *Eur J Contracept Reprod Health Care*. 2010;15:54–S66

⁴² Dixon-Mueller R. How young is "too young"? Comparative perspectives on adolescent sexual, marital and reproductive transitions. *Stud Fam Plan*. 2008, 39:247–62, 14; Spriggs AL, Halpern CT. Sexual debut timing and depressive symptoms in emerging adulthood. *J Youth Adolesc*. 2008;37:1085–96; Dickson N, Paul C, Herbison P, Silva P. First sexual intercourse: age, coercion, and later regrets reported by a birth cohort. *BMJ*. 1998;316:29–33.

⁴³ McBride O, Morgan K, McGee H. [Irish Contraception and Crisis Pregnancy Study 2010](#) (ICCP-2010) A survey of the general population, 2012. [http:// crisispregnancy.ie/wp-content/uploads/2012/06/ICCP-2010_REPORT.pdf](http://crisispregnancy.ie/wp-content/uploads/2012/06/ICCP-2010_REPORT.pdf).

Accessed 21 July 2013. 22; Rundle K, Layte R, McGee H. The Irish study of sexual health and relationships sub report 1: learning about sex and first sexual experiences. Crisis Pregnancy Agency: Dublin; 2008.

⁴⁴ McHale E, Newell J. Sexual behaviour and sex education in Irish school going teenagers. *Int J STD AIDS*. 1997;8:196–200; Bonner C. A report on the sexual practices of 16–18 year olds in the midland health board. Tullamore: Department of Public Health, Midland Health Board; 1996.

⁴⁵ Young H, Burke L, Nic Gabhainn S. [Sexual intercourse, age of initiation and contraception among adolescents in Ireland: findings from the Health Behaviour in School-aged Children \(HBSC\) Ireland study](#). *BMC Public Health*. 2018;18:362. doi:10.1186/s12889-018-5217-z.

⁴⁶ *Ibid*, 2018:6

⁴⁷ *Ibid*, 2018: 7

⁴⁸ *Ibid*, 2018:8

⁴⁹ *Ibid*, 2018:8

⁵⁰ *Ibid*, 2018: 12

boys and 6% of girls reported using no method of contraception at last intercourse. Older boys from higher income homes were more likely to use a condom at last intercourse.⁵¹ This study suggests that young people's age of sexual initiation is lower in Ireland than in the UK where the most recent British National Survey of Sexual Attitudes and Lifestyles (Natsal-3) found that among those aged 16–24, 30.9% reported heterosexual intercourse before the age of 16 years.⁵² The Irish study also points to the wisdom of incorporating Relationships and Sexuality Education (RSE) within a broader Social Personal and Health Education (SPHE) programme as communication with friends, bullying or being bullied, peer support and/or pressure were found to be important predictors of when or how early sexual initiation took place. Alcohol, tobacco and cannabis involvement were associated with sexual initiation among both boys and girls, and cannabis in particular was found to be associated with very early initiation for both boys and girls. Alcohol consumption was associated with very early sexual initiation among boys only.⁵³ These findings correspond with international research, which points to clear links between substance use, sexual risk taking and early sexual initiation.⁵⁴

It should be noted that Young *et al*'s nationally representative study does not examine sexual risk taking by sexual orientation or gender identity. The [LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland](#) is the largest study of Lesbian Gay Bisexual Transgender and Intersex (LGBTI) people (see Appendix B for definitions) to date that examines the mental health and wellbeing of LGBTI people in Ireland, with a special emphasis on young people. The lifetime prevalence rate for use of any illegal drug in the general population was lowest amongst younger age groups (15-24 year olds). In the *LGBTIreland* study, however, 49.9% of participants aged 14-25 years had taken drugs recreationally, which as also highlighted by international studies, increases the likelihood of sexual risk taking and very early sexual initiation.^{55 56} The *LGBTIreland* study also found that young people were at increased risk of being bullied in school and that this experience influenced the onset of mental health difficulties for young people. Close to one quarter of 14-18 year old (23.6%) and 19-25 year old (23.2%) study participants reported missing or skipping school to avoid bullying⁵⁷. Young *et al* also found that being bullied in school is associated with very early sexual initiation, which when combined with the findings of the *LGBTIreland* report suggests that Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI – see Appendix B for definitions) young people are at particular risk of poorer sexual health outcomes. These findings are further reinforced in the context of epidemiological data on STIs and HIV in Ireland (see below).

3.2 Sexually Transmitted Infections (STIs) in Ireland

The highest prevalence of Sexually Transmitted Infections (STIs) in Europe are among young adults (15-24 years) and MSM. There has been an increasing trend in STI notifications in Ireland since the 1990s, which may be due to improvements in testing methods, improved access to testing and screening, more comprehensive surveillance, as well as ongoing unsafe sexual behaviours.⁵⁸ Young adults in general are more likely to contract Chlamydia, Trachomatis infection and Gonorrhoea, while a more significant burden of Gonorrhoea and Syphilis tends to affect

⁵¹ Ibid, 2018: 11

⁵² Mercer C, Tanton C, Prah P, Erens B, Sonnenber P, Clifton S, et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Survey of sexual attitudes and lifestyles (Natsal). *Lancet*. 2013;382:1781–94.

⁵³ Young *et al*, Sexual intercourse, age of initiation and contraception among adolescents in Ireland. 2018: 12

⁵⁴ Jackson C, Sweeting H, Haw S. Clustering of substance use and sexual risk behaviour in adolescence: analysis of two cohort studies. *BMJ Open*. 2012;2:55; Wiefferink CH, Peters L, Hoekstra F, Ten Dam G, Buijs GJ, Paulussen TG.

Clustering of health-related behaviours and their determinants: possible consequences for school health interventions. *Prev Sci*. 2006;7:127–49; Spriggs Madkour A, Farhat T, Tucker Halpern C, Godeau E, Nic Gabhainn S.

Early adolescent sexual initiation as a problem behaviour: a comparative study of five nations. *J Adolesc Health*. 2010;47:389–98.57; Connell C, Gilreath T, Hansen N. A multiprocess latent class analysis of the co-occurrence of substance use and sexual risk behaviour among adolescents. *J Stud Alcohol Drugs*. 2009;70:943–51.

⁵⁵ Ibid

⁵⁶ Higgins, A., Doyle, L., Downes, C., Murphy, R., Sharek, D., DeVries, J., Begley, T., McCann, E., Sheerin, F., Smyth, S. *LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland*. Published by GLEN and BeLonG To, Dublin. 2016

⁵⁷ Higgins, A. et al, *LGBTIreland Report*, 2016: 21-29

⁵⁸ Health Protection Surveillance Centre, [Trends in Sexually Transmitted Infections in Ireland, 1995 to 2012](#), (Dublin: 2013)

MSM.⁵⁹ Between 2016 and 2017, the number of STIs reported in the 15 - 24 year old age group increased by 11%⁶⁰ as indicated by Table 1. MSM accounted for all cases 100%) of Lymphogranuloma Venereum (LGV)⁶¹ in 2017 and, where mode of transmission is known, 88% of Syphilis cases and 62% of Gonorrhoea cases identified in 2017 across all age categories⁶² - see Table 1:

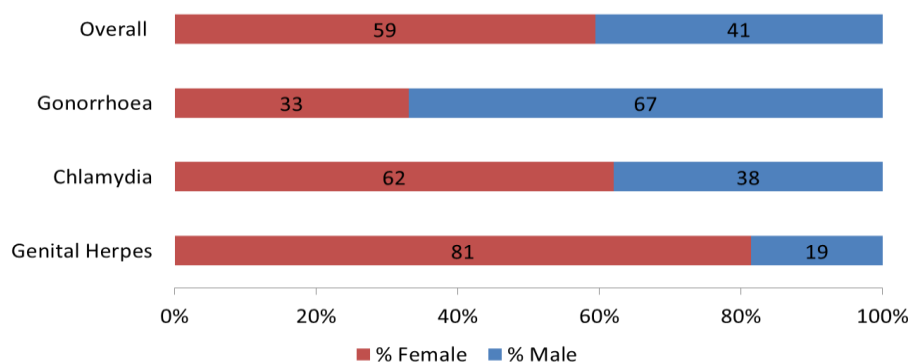
Table 1: Sexually Transmitted Infections in Young People 2017.

STIs in 15-24 year-olds	2017 N	2016 N	% change 2016-2017
Chlamydia trachomatis infection	3730	3362	+10.9
Gonorrhoea	872	732	+19.1
Herpes simplex (genital)	598	583	+2.6
Total	5200	4677	+11.2

Source: Health Protection Surveillance Centre, 2017⁶³

Of those testing positive for an STI in Ireland in 2017, 59% were young women and 41% were young men: more women than men tested positive for Chlamydia and Genital Herpes, but more young men tested positive for Gonorrhoea⁶⁴ (see Figure 1). Chlamydia in young people constituted 50% of all cases reported, while Gonorrhoea in young people was 39% of all cases reported in this age category in 2017. Genital Herpes in young people was 38% of all cases reported in 2017.

Figure 2: Sexually Transmitted Infections in Young People, 2017: Distribution by Sex



Source: Health Protection Surveillance Centre, 2017⁶⁵

⁵⁹ European Centre for Disease Prevention and Control. [Sexually transmitted infections in Europe 2013](#). Stockholm: ECDC; 2015.

⁶⁰ Across all age categories, STI's increased by 10% between 2016 and 2017.

⁶¹ Lymphogranuloma Venereum (LGV) is a bacterial infection that is acquired through unprotected oral, anal, or vaginal sex with an infected person, as well as engaging in other sex acts like fisting or using sex toys – www.spunout.ie

⁶² Health Protection Surveillance Centre, [Sexually Transmitted Infections in Ireland – Provisional Data Report, 2017](#) Dublin: 11th May 2018

⁶³ Health Protection Surveillance Centre, [Sexually Transmitted Infection Surveillance Report among Young People in Ireland, 2017](#) Dublin: 18th May 2018

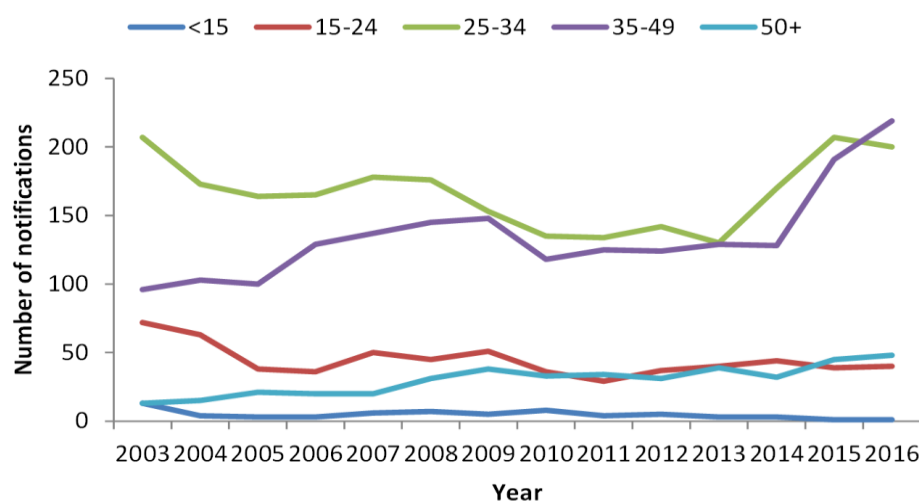
⁶⁴ Across all age categories more men (53%) than women (47%) tested positive for an STI in 2017 (HPSC: 2018 report)

⁶⁵ Ibid

3.3 HIV and AIDS in Ireland

The number of people testing positive for Human Immunodeficiency Virus (HIV) has also been increasing in Ireland since 2014. In 2016, the median age of adult cases at HIV diagnosis was 35 years (range: 18 to 72 years) with the highest proportion of diagnoses (43%) identified in those aged 30-39 year olds. Eight percent of cases (n=41) were reported in young people (15-24 years of age) (see Figure 2).⁶⁶ Of the 508 new diagnoses of HIV reported in 2016, sex between men was the predominant mode of HIV transmission (51%), followed by heterosexual transmission (28%), while 4% were among people who inject drugs (PWID). Twenty five percent (n=129) of new diagnoses in 2016 were born in Ireland and 61% (n=311) were born overseas (36% in sub-Saharan Africa and 33% in Latin America). The rate of HIV diagnosis among those who were born in Ireland remained relatively stable between 2003 and 2016 (3.4 to 4.2 per 100,000 population) but the rate among migrant populations has increased significantly in the same timeframe (18.4 in 2011 to 38.4 per 100,000).⁶⁷ Of the 14 people with an AIDS defining illness⁶⁸ at the time of HIV diagnosis in 2016, eight were heterosexual and six were MSM.

Figure 3: HIV Notification by Age Group 2003-2016



Source: Health Protection Surveillance Centre, 2017⁶⁹

3.4 Crisis Pregnancy in Ireland

The number of women travelling to the UK for an abortion has been declining since 2001 when 6,673 women with an address in the Republic of Ireland had the procedure. In 2017, 3,092 women living in Ireland had an abortion in the UK which is less than half the number than in 2001 and a further 5% decline from 2016 (See Figure 3).⁷⁰

A study by Aiken *et al* demonstrated that 1,642 abortion pill packages were sent to Ireland in the 3 year period 2010 to 2012 by a single provider.⁷¹ Uptake of at-home medical termination of pregnancy may account for the exponential decline in the number of women accessing termination

⁶⁶ Health Protection Surveillance Centre, [HIV Report, 2016](#). HSE, 2017: 4

⁶⁷ *Ibid*, 2017: 10-11

⁶⁸ There are a number of life-threatening diseases that can present in HIV-positive people that are called "AIDS-defining" illnesses. This means that when a person has one of these illnesses, they are said to be diagnosed with the advanced stage of HIV infection known as AIDS.

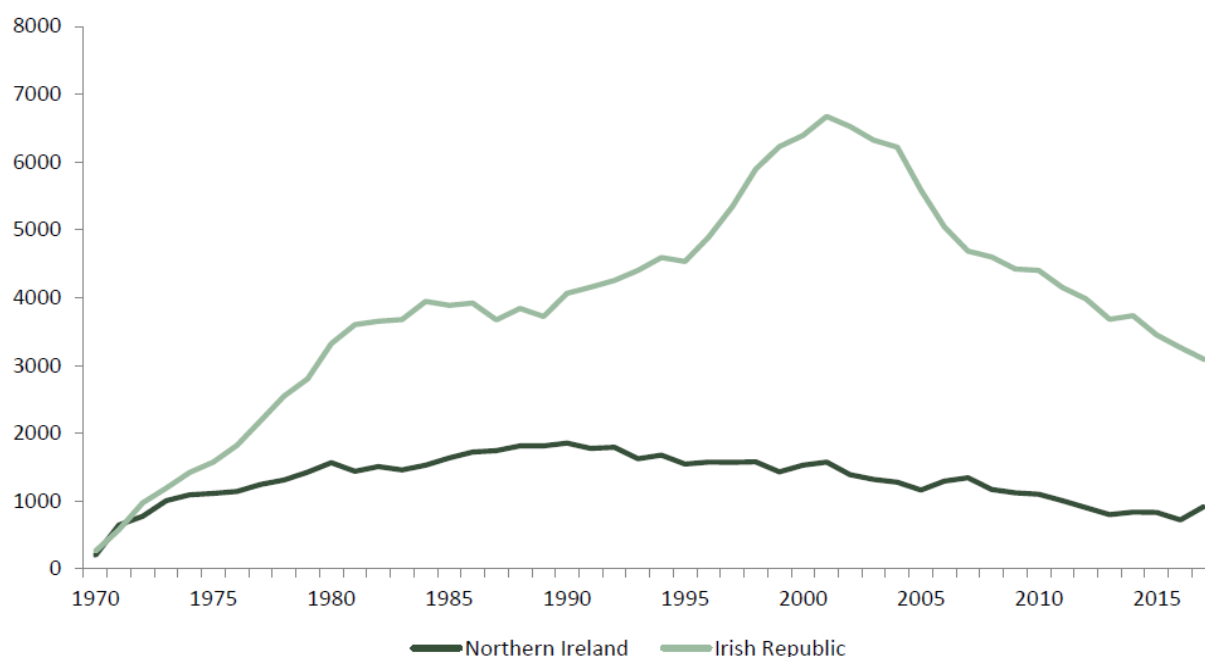
⁶⁹ Health Protection Surveillance Centre, [HIV in Ireland, Latest Trends](#), November 2017

⁷⁰ Department of Health and Social Care, [Abortion Statistics, England and Wales: 2017: Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales](#). Published June 2018: pp20

⁷¹ Aiken ARA, Gomperts R, Trussell J. [Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis](#). BJOG 2017; 124:1208–1215.

of pregnancy procedures in the UK but other factors – including the possibility of more effective family planning – may also be at play. However, it is currently unclear if there is an association between the decline in the number of women accessing abortion in the UK and the increase in the number of women accessing abortifacients⁷² online.

Figure 4: Number of Abortions for Residents of Northern Ireland and the Republic of Ireland, 1970-2017⁷³



Source: United Kingdom Department of Health and Social Care, 2018

The review of RSE is taking place against a backdrop of rising incidences of HIV and STIs, and while there appears to be a decrease in the number of women accessing abortion in the UK, there is a corresponding increase in the number accessing abortifacients from online sources. These public health concerns are compounded by risk behaviours and patterns of sexual activity among young people, particularly those with other vulnerabilities including members of the Travelling community or young people who identify as LGBTI.

⁷² A substance or drug that induces an abortion.

⁷³ Department of Health and Social Care, [Abortion Statistics, England and Wales: 2017: Summary information from the abortion notification forms returned to the Chief Medical Officers of England and Wales](#). Published June 2018: pp20

4. Historical Overview of School-based Sexuality Education in Ireland

Chapter Summary

- The sex education debate in Ireland and internationally operates on a continuum between “moral relativism”, which refers to the philosophical view that there is no objectively determined measure of ‘right’ or ‘wrong’, and “moral absolutism” which is based on the belief that there is always one right answer to any ethical question. This is why sex education is contested in every jurisdiction;
- Throughout the 1970s and 1980s, some regional health authorities had attempted to provide sex education in various locations but efforts tended to be piecemeal, inconsistent and uncoordinated, while dependent on the personal value system of key individuals;
- The Health Education Bureau (HEB) championed “lifeskills” education in Ireland in the 1980s, which was a non-directive, person-centred approach that was in stark contrast to the traditional Catholic ethos in which right may be objectively and absolutely discerned from wrong;
- While calls for school-based sex education originate with concerns for crisis pregnancy, the fear surrounding AIDS mobilised political support with Dáil and Seanad motions and debates between 1988 and 1989 demonstrating a clear majority in favour of its introduction;
- The *AIDS Education Resource* was officially introduced in post-primary and vocational schools throughout the country on 2nd October 1990: it was the forerunner of the current RSE programme;
- The *Expert Advisory Group on Relationships and Sexuality Education* - set up by then Minister for Education, Niamh Breathnach, T.D., in April 1994 - concluded that the school had a role to play in supporting and complementing the work of the home in sex education. The Advisory Group recommended that RSE should be a required part of the curriculum and a timetabled component of SPHE in each primary and post-primary school in Ireland, starting at Junior primary level;
- Following the *Report of the Advisory Group on Relationships and Sexuality Education*, a National Co-ordinator for RSE was appointed in 1995 and *Interim Curriculum Guidelines for RSE as an aspect of SPHE* were developed by the *National Council for Curriculum Assessment* in 1996;
- RSE was implemented as a mandatory component of SPHE in Ireland in 1997: It was recommended that the core values and ethos of the school should be clearly articulated in the school policy, with due regard for the views of parents.

4.1 Overview

Ireland’s relationship with school-based sex education is not particularly unique in that the same debate – marked by conservative and liberal ideological positions described in Chapter 1 – polarised the argument from the outset. Where public debate commenced and gained some momentum in Britain and a number of other European countries in the decades after World War II,⁷⁴ the moral authority of the Catholic Church in Ireland delayed discussion until rising rates of crisis pregnancy ignited concern in the late 1970s. The degree of sexual ignorance which prevailed in the population was highlighted by social and medical researchers like Brennan and Sweetman,⁷⁵ while prompting criticism from both internal and external sources.⁷⁶ In 1978, Ruarc

⁷⁴ Limond, D., “I never imagined that the time would come”: Martin Cole, the Growing Up Controversy and the Limits of School Sex Education in 1970s England. *History of Education*, 2006. 34(5): p. 1-21; Carter, J.B., *Birds, Bees, and Venereal Disease: Toward an Intellectual History of Sex Education*. *Journal of the History of Sexuality*, 2001. 10(2): p. 213-249.

⁷⁵ Sweetman, R., *On Our Backs: Sexual Attitudes in a Changing Ireland*. 1979, London: Pan Books Ltd.

Gahan, a Dublin school teacher, conducted a survey with 879 young people who had left school in 1975 or later to establish the level of provision of sex education in secondary schools in Dublin City and County. He reported that while there were isolated and notable exceptions, the vast majority of respondents described “...ignorance, worry, secretiveness and embarrassment” regarding sex.⁷⁷

The impetus behind calls for school-based sex education arose in response to rising rates of crisis pregnancy and abortion. In 1979, a group of gynaecologists from the Royal College of Surgeons in Ireland and the Rotunda Hospital highlighted significant increases in the number of girls under the age of seventeen years presenting with unwanted pregnancies and the rise in therapeutic abortions sought by young Irish women in the United Kingdom (UK). These increases prompted clinicians to develop a programme of sex education which they delivered in post-primary schools throughout Ireland while arguing candidly for a programme of sex education to be introduced.⁷⁸ On foot of these events, a Dáil question was put to John Wilson, then Minister for Education, as to whether in light of the increase in teenage pregnancies, a programme of sex education may be introduced in schools. He responded:

...the primary responsibility in this matter rests on the parents. School managements naturally supplement parental initiative within the measure of their own capability and I understand that sex education is already provided for in the human development programmes and the guidance and pastoral care programmes offered by secondary schools.⁷⁹

The then Minister was referring to *ad hoc* provision of sex education that was delivered as part of human development or pastoral care programmes at the discretion of the school principal but was neither mandatory, regulated nor guided by the Department of Education at the time⁸⁰. Throughout the 1970s and 1980s, some regional health authorities had attempted to provide sex education modules in various locations but efforts tended to be piecemeal, inconsistent and uncoordinated and dependent on the personal value system of key individuals.⁸¹ Cork City and the North Western Health Board region were particularly proactive, producing materials throughout the 1980s that addressed issues of sex, sexuality and contraception. The absence of guidance and direction from the Department of Education, however, generated a climate of uncertainty in which schools were cautious and unclear about what issues could be included in pastoral care programmes.⁸²

4.2 “Lifeskills” controversy

The Health Education Bureau (HEB) was established by the Minister for Health under the Health Education Bureau (Establishment) Order, 1975. The bureau was obliged to advise the Minister on the aspects of health education which should have priority at national level, and it was given considerable funding by Charles Haughey during his tenure as Minister for Health in 1979.⁸³ The HEB’s philosophy was largely informed by the Rogerian person-centred-approach⁸⁴ and as such was non-directive, while encouraging students to “clarify their value systems in relation to lifestyle options”.⁸⁵ Such a method was in stark contrast to the traditional Catholic ethos based on a belief

⁷⁶ Nolan, A., The transformation of school-based sex education policy in the context of AIDS in Ireland, *forthcoming* Irish Educational Studies, Vol. 38: Issue 3, September 2018

⁷⁷ Gahan, R., Sex education in our second-level schools, *The Irish Times* (1921-Current File); Jan 10, 1980

⁷⁸ Thornton, C., Brennan, R., Denham, P., Browne, A., Sex Education by the Gynaecologist – Analysis of a School Programme in Ireland, *Irish Medical Journal*, February 1979

⁷⁹ Ceisteanna—Questions. Oral Answers. Sex Education Courses. Wednesday, 23 May 1979. Dáil Éireann debate, Vol. 314 No. 8

⁸⁰ Nolan, *forthcoming* Irish Educational Studies, Vol. 38: Issue 3, September 2018

⁸¹ *Ibid*

⁸² *Ibid*

⁸³ Butler, S., *Alcohol, Drugs and Health Promotion in Modern Ireland*. (Dublin: Institute of Public Administration. 2002)

⁸⁴ Wood, J.K., *Carl Rogers' person-centered approach: Toward an understanding of its implications* 2008, Ross-on-Wye: PCCS Books. A person centred approach is focused on the needs, wants, desires and goals of the individual.

⁸⁵ Butler, S. 2002: 179

that right may be objectively and absolutely discerned from wrong and that the function of education is to teach objective morality in a directive way.⁸⁶ A number of conservative Roman Catholic groups committed to the retention of traditional family values had emerged in the wake of the abortion referendum in 1983 and developed a “coherent, sustained and public critique of lifeskills programmes generally and of the HEB in particular.”⁸⁷

Former Archbishop of Dublin, Kevin McNamara was deeply critical of the HEB’s lifeskills approach arguing that it dissolved the values of a shared Christian vision and adopted philosophies of relativism and emotivism that undermined Catholic social teaching.⁸⁸ In 1987, Jeremiah Newman, Bishop of Limerick, devoted a book to the subject of what he perceived to be the encroachment of the state into the affairs of the family. He expressed concern at how quickly the “values clarification” approach to lifeskills education had “caught on in Ireland” and assisted by the Health Education Bureau had “permeated some places almost surreptitiously”⁸⁹. The Bishops were joined by conservative lay groups who resisted state involvement in the provision of sex education and were opposed to the philosophy of *moral relativism*⁹⁰ which underpinned the HEB’s approach to the development of sex education materials. These *moral absolutists*⁹¹ presented a reasoned, coherent argument at the time in several publications, including one periodical called the ‘Ballintrillick Review’, the editor of which, Doris Manly, claimed that,

*Before the revolution [in lifeskills education], Irish schools taught that some actions were right and others were wrong...But in these HEB programmes, the same schools are now giving teenagers the impression that whatever a person wants to do is therefore right for him...And nobody bothered to tell the kids’ parents – until people like me began making a bit of a rumpus.*⁹²

The HEB largely ignored criticisms and concerns expressed by these groups, persevering with the development of programmes that reflected a growing person-centred trend in education while disregarding the prevailing Catholic moral context into which their programmes were to be delivered.

The death of Ann Lovett - a fifteen year old schoolgirl from Granard in County Longford who was found in late January 1984, having given birth to a baby boy at a local grotto – prompted a renewed emphasis and all-party support for the development of a programme of sex education in schools but opposition to the HEB’s lifeskills approach met with such forceful opposition that the plan was abandoned in 1985 and the function of the HEB was subsumed into the Department of Health in September 1987.⁹³

The tensions between moral relativism and moral absolutism, liberal and conservative approaches to sex education remain decidedly contemporary: in an opening statement on Relationships and Sexuality Education on 5th July 2018 to the Oireachtas Committee on Education and Skills, the

⁸⁶ Newman, J., *Puppets of utopia: can Irish democracy be taken for granted?* (Four Courts Press: Dublin, 1987); McNamara, Archbishop K. in *Curriculum and Values in Education*. (Dublin: Veritas Publications, 1987)

⁸⁷ Butler, 2002: 179

⁸⁸ Archbishop Kevin McNamara, *Curriculum and Values in Education*, 1987

⁸⁹ Bishop Jeremiah Newman, *Puppets of utopia*, 1987:20

⁹⁰ “*Moral relativism*” refers to the philosophical view that there is no objectively determined measure of ‘right’ or ‘wrong’. As such morals are relative to the traditions, convictions, values and practices of an individual or a group of people. It is a non-judgemental philosophical position that urges people to act in a way that is right for them adopting an “each to their own” position. “*Moral relativism*” is on the opposite end of the continuum from “*moral absolutism*” which claims that there is always one right answer to any ethical question.

⁹¹ “*Moral absolutism*” is on the opposite end of the continuum from “*moral relativism*.” *Moral absolutism* operates on the premise that there is always one right answer to any ethical question, and that some actions are intrinsically right or wrong.

⁹² Manly, D., *The Ballintrillick Review*, (Autumn 1987 p.12); Manly, D., Browne, L., Cox, V., Lowry, N., *The Facilitators* (Dublin: Brandsma Books Limited, 1986)

⁹³ Doris Manly, *Ballintrillick Review*, p.12

Joint Managerial Body, in outlining the perspective of post-primary faith schools, quoted Archbishop Eamon Martin who had said at their annual conference in May 2018:

*Relationships and Sexuality Education ought to be an integral part of the curriculum in a Catholic school ... (but) should not be reduced to the imparting of so-called “objective” information, dissociated from a morals and values framework or from the totality of relationships.*⁹⁴

While the *Talking Relationships Understanding Sexuality Teaching Resource* (TRUST) contains a number of lesson plans that support the delivery of the RSE programme including contraception and decision-making, it is at the discretion of the school and the SPHE department if it wishes to deliver on these topics.⁹⁵

4.3 The introduction of sex education ‘by stealth’

AIDS⁹⁶ is now a treatable condition with almost normal life expectancy but in 1985 every country in the world had reported at least one case of AIDS, for which there was then no cure, and it was predicted that AIDS would wipe out a significant proportion of the global population by the end of the decade. This threat to Ireland’s health opened a ‘window of opportunity’⁹⁷ which groups and individuals committed to liberal public health principles in both health and education sectors seized upon. While not unanimous, AIDS renewed emphasis and mobilised political support for the nationwide introduction of school-based sex education with Dáil and Seanad motions and debates between 1988 and 1989 demonstrating a clear majority in favour.⁹⁸ This momentum was capitalised upon by then Minister for Education, Mary O’Rourke, who stood down opposition from the Bishops and the conservative lay groups to the development and nationwide introduction of an AIDS Education Resource, which incorporated all the core elements of sexuality education. O’Rourke was disinclined to engage in open controversy with the Bishops, making her position clear from the outset: “they [the Bishops] have their bailiwick and I have mine.”⁹⁹

The Association of Secondary School Teachers in Ireland (ASTI) went so far as to recommend the AIDS Education Resource to its members instead of materials that had been developed by the Catholic Bishops in May 1989¹⁰⁰ and it was also welcomed by the Teachers Union of Ireland (TUI).¹⁰¹

The AIDS Education Resource was officially rolled out in schools throughout the country on 2nd October 1990. It contained controversial elements, which the Bishops’ had objected to including references to anal sex, oral sex, condom use and masturbation¹⁰². In deference to the Bishops, the section on condoms was revised to include a statement that condoms were not always reliable, with recommendation that the moral issues surrounding AIDS should be “dealt with in accordance with the school ethos and the wishes of parents.”¹⁰³

⁹⁴ John Curtis, JMB General Secretary, JMB Opening Statement on Relationships and Sexuality Education to the Oireachtas Joint Committee on Education and Skills, 5th July 2018

⁹⁵ SPHE Course Overview – courtesy of the Department of Education and Skills by email to the author dated 6th July 2018. Ann Nolan.

⁹⁶ “The Gay Community Response to the Emergence of AIDS in Ireland: Activism, Covert Policy, and the Significance of an “Invisible Minority”.” *Journal of Policy History* 30, no. 1 (2018): 105-127. <https://muse.jhu.edu/> (accessed July 16, 2018).

⁹⁷ The term AIDS is used here in recognition that in the mid-late 1980s this was the term most commonly used in literature and discourse worldwide. Contemporary audiences will be more familiar with the separation of the definitions Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

⁹⁸ Kingdon, J.W., *Agendas, Alternatives, and Public Policies* - second edition. 2003, New York, London: Longman, p.165

⁹⁹ Seanad Éireann Debate, Vol. 118 No. 14; Dáil Éireann Debate, Vol. 379 No. 1; Dáil Éireann Debate, Vol. 393 No. 2

¹⁰⁰ Walsh, J., Bishops likely to accept new AIDS plan for schools, *The Irish Times* (1921-Current File); Oct 2, 1990; ProQuest Historical Newspapers: The Irish Times (1859-2011) and The Weekly Irish Times (1876-1958)

¹⁰¹ “AIDS – A Guide for Teachers and Educators Who Share with Parents the Responsibility of Educating Children and Students about the Disease”. Education Secretariat in Diocesan House, Drumcondra.

¹⁰² Ibid

¹⁰³ Departments of Education and Health, AIDS Education Resource, (Dublin: Stationary Office, 1989)

¹⁰⁴ Ibid: 9

The AIDS Resource, while recommended by the Department of Education which offered in-service training to teachers, was not a mandatory component of the school curriculum. Consequently, delivery of the programme¹⁰⁴ appears to have been “very piecemeal and very hit and miss” while the level of detail provided by teachers or whether or not the programme was delivered at all was largely “...determined by people’s beliefs and values.”¹⁰⁵ In October 1990, a form of sex education had been introduced - as Dr. James Walsh, the National AIDS Co-ordinator and deputy Chief Medical Officer described it “by stealth”¹⁰⁶ – into Ireland’s post-primary and vocational schools. AIDS succeeded where crisis pregnancy had failed to overcome opposition to the introduction of sex education. As such, the *AIDS Education Resource* made it possible for the RSE programme to be introduced on a mandatory basis in 1997.

4.4 The Expert Advisory Group on Relationships and Sexuality Education

Minister for Education, Niamh Breathnach, T.D., established the Expert Advisory Group on Relationships and Sexuality Education in April 1994. This group concluded that RSE provision in the state was “generally uneven, unco-ordinated and sometimes lacking.”¹⁰⁷ While acknowledging that parents are the primary educators of their children, they argued that the school has a role to play in supporting and complementing the work of the home in this regard. The Advisory Group recommended that RSE should be a required part of the curriculum and a timetabled component of SPHE in each primary and post-primary school, starting at junior primary level. The group further recommended that the core values and ethos of the school should be clearly articulated in the school policy, with due regard for the views of parents.¹⁰⁸

Following the *Report of the Advisory Group on Relationships and Sexuality Education*, a National Co-ordinator for RSE was appointed in 1995 and Interim Curriculum Guidelines for RSE as an aspect of SPHE were developed by the National Council for Curriculum Assessment in 1996. This document positioned RSE within the overall framework of Social Personal and Health Education (SPHE) and aimed:

- to help young people understand and develop friendships and relationships;
- to promote an understanding of sexuality;
- to promote positive attitudes to one’s own sexuality and in one’s relationships with others;
- to promote knowledge and respect for reproduction;
- to enable young people to develop attitudes and values towards their sexuality in a moral, spiritual and social framework.¹⁰⁹

The guidance is underscored by three themes of RSE at post-primary junior cycle and senior cycle levels:

- Human growth and development;
- Human sexuality;
- Human relationships.¹¹⁰

These themes are developed differently at each level. **Junior cycle themes** are elaborated in Table 5

¹⁰⁴ A review of the programme was commissioned by the Department of Education but Nolan (forthcoming 2018) reports neither the Department nor key informants were able to locate a copy of this report.

¹⁰⁵ Nolan, forthcoming Irish Educational Studies, Vol. 38: Issue 3, September 2018, p.14

¹⁰⁶ Ibid: 15

¹⁰⁷ Ibid, 1995, p.19

¹⁰⁸ Ibid, 1995,p.19

¹⁰⁹ National Council for Curriculum Assessment, Relationships and Sexuality Education, as aspect of Social Personal and Health Education, Interim Curriculum Guidelines for Post-Primary Schools. 1996: 10

¹¹⁰ Ibid, 1996: 17

Table 2: Junior Cycle Themes in RSE¹¹¹

<ul style="list-style-type: none"> • Human Growth and Development <ul style="list-style-type: none"> ○ awareness of changes in the human life cycle; ○ an understanding of the physical and emotional changes that take place in males and females at puberty and appreciation of variation; ○ knowledge of sexual organs and their function; ○ an appreciation of hygiene associated with puberty; ○ an awareness of the sometimes conflicting feelings, moods and emotions characteristic of adolescence; ○ development of a language for the expression of emotions; ○ an understanding of fertility, conception, pregnancy and birth; ○ awareness of implications of sexual activity; ○ understanding of STIs, with particular reference to HIV/AIDS. • Human sexuality <ul style="list-style-type: none"> ○ an awareness of what it is to be male and female; ○ an awareness of stereotyping and its influence on attitudes and behaviour; ○ an appreciation of equality and difference; ○ information on and sensitivity to sexual orientation; ○ awareness of discrimination; ○ respect for sexuality; ○ developing skills for personal safety. • Human relationships <ul style="list-style-type: none"> ○ developing skills for self awareness; ○ developing skills for building and maintaining self-esteem; ○ awareness of the qualities valued in friendships; ○ developing skills for building and maintaining friendships; ○ awareness of roles and responsibilities in relationships and families; ○ identifying groups students belong to, behaviour in these groups and response to peer pressure.

Senior cycle themes are elaborated in Table 5

Table 3: Senior Cycle Themes in RSE¹¹²

<ul style="list-style-type: none"> • Human Growth and Development <ul style="list-style-type: none"> ○ understanding the structure and function of sex organs; ○ awareness of fertility; ○ awareness of the importance and methods of family planning; ○ understanding of pregnancy and the development of the foetus; ○ appreciation of the importance of health care during pregnancy; ○ recognising the range of human emotions and ways to deal with these; ○ an understanding of the relationship between safe sexual practice and sexually transmitted diseases, with particular reference to HIV/AIDS. • Human sexuality <ul style="list-style-type: none"> ○ understanding of what it is to be male and female; ○ consideration of male and female roles in relationships and society; ○ awareness and understanding of sexual orientations; ○ awareness of some of the issues pertaining to equality; ○ understanding the concept of sexual harassment and its different forms; ○ awareness of sexual abuse and rape, including legal issues and the identification of help agencies in these areas; ○ skills for making choices about sexual activity;
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¹¹¹ Ibid

¹¹² Ibid

- exploration of the range of attitudes, values and beliefs regarding sexual behaviour in modern society.
- **Human relationships**
 - understanding the nature of peer pressure;
 - developing skills for resolving conflict;
 - development of an awareness of the complex nature of love and loving relationships;
 - understanding marriage as a loving commitment;
 - deeper awareness of the importance of family life.

The current RSE programme delivered to post-primary schools throughout Ireland is still informed by the guidance of the Expert Advisory Group on Relationships and Sexuality Education (1994) and the Interim Curriculum Guidelines for Post-Primary Schools developed by the National Council for Curriculum Assessment, Relationships and Sexuality Education, as an aspect of Social Personal and Health Education in 1996. The next chapter will examine the current provision for RSE as an integrated aspect of SPHE in the context of programme evaluations and reviews that have been undertaken since 1997.

5. Current Provision for Relationships and Sexuality Education (RSE) in Ireland

Chapter Summary

- RSE is mandatory and must be provided to all students in both junior and senior cycles;
- At the end of the three years of the junior cycle, students will:
 - Examine the stages of development from conception to birth
 - Understand the different types of relationships
 - Be aware of the feelings and emotions associated with a variety of friendships
 - Understand the role of peer pressure and other influences in the area of sexuality
 - Develop the skills necessary for making decisions consistent with personal values and within a moral framework, about behaviours in relationships
 - Have a knowledge of sexually transmitted diseases
- In senior cycle, the *Interim Curriculum and Guidelines* suggests topics that schools may cover but it is anticipated that students should continue to develop their knowledge and understanding about:
 - the reproductive system;
 - family planning;
 - personal integrity;
 - sexually transmitted diseases;
 - sexual harassment;
 - gender orientation;
 - sexual discrimination;
 - personal rights and personal safety;
 - loving & respectful relationships;
 - responsible decision making.
- A national survey of primary and post-primary teachers, parents and schools found overwhelming support for school-based sexuality education, with teachers reporting a high level of satisfaction with the training they had received;
- Mayock, Kitching and Morgan (2010) found that 66.6% of schools surveyed reported that RSE implementation levels had improved since its introduction in 1997 but the study identified significant variance in the quality of RSE delivery. The DES Inspectorate (2013) also found significant variation in the quality of RSE provision;
- Mayock, Kitching and Morgan argued that the absence of explicit directives and teaching resources for specific and often sensitive topics, means in practice that students do not have equal opportunities for learning, discussion and debate on some aspects of sexuality;
- A survey conducted among 13 to 24 year old LGBT+ young people in 2017 found that 39% complained of the absence of inclusive sex education in schools;
- Almost all of schools are providing a programme of RSE for senior cycle students significant variation in the quality of provision has been identified: RSE was found to be good or very good in 70% of schools evaluated but weaknesses outweighed strengths in 27% of schools;
- In almost half of the schools evaluated by the Inspectorate (2013), practices and procedures that supported subject planning for RSE tended not to be as effective as planning for SPHE;
- There is a perceived failure of RSE to deal with a range of sensitive topics, while the programme's focus on sexuality as a subject precludes an understanding of sex in pleasurable and desirable terms.

5.1 Overview of the current programme¹¹³

Social, Personal and Health Education (SPHE) provides students with an opportunity to develop the skills and competencies to learn about themselves, to care for themselves and others and to make informed decisions about their health, personal lives and social development. The SPHE curriculum endeavours to continue the learning from primary school. To key aims are:

- To enable students to develop a framework for responsible decision making; and
- To promote physical, mental and emotional health and wellbeing

The curriculum for SPHE in the junior cycle is presented in ten modules which should be delivered each year. However, each module should be taught in a developmental manner over the course of the three years. This approach ensures that learning evolves and is reinforced for students. The ten modules are:

- Belonging and integrating;
- Self-management: a sense of purpose;
- Communication skills;
- Physical health;
- Friendship;
- Relationships and sexuality (RSE);
- Emotional health;
- Influences and decisions;
- Substance use; and
- Personal safety.

RSE is mandatory and must be provided to all students in both junior and senior cycles. At the end of the three years of the junior cycle, students will,

- Examine the stages of development from conception to birth;
- Understand the different types of relationships;
- Be aware of the feelings and emotions associated with a variety of friendships;
- Understand the role of peer pressure and other influences in the area of sexuality;
- Develop the skills necessary for making decisions consistent with personal values and within a moral framework, about behaviours in relationships;
- Have a knowledge of sexually transmitted diseases.

The SPHE curriculum which includes RSE in junior cycle is designed to be broad and to allow schools autonomy to decide when particular topics should be delivered. Resource Materials for RSE for both junior and senior cycle were developed and approved by the DES to support schools in delivering the RSE programme and contains detailed lesson plans. For instance in Lesson 8 in the resource materials for junior cycle, students learn about pregnancy and family planning methods that are available. Students learn about the consequences of unprotected sex in terms of pregnancy and sexually transmitted diseases. Lesson 20 develops students' understanding of and resilience to peer pressure but this is not explicitly related to sexual consent.

In senior cycle, the Interim Curriculum and Guidelines contain a number of topics which schools can cover. The guidelines state clearly that the list of topics is suggested and that the school when developing its own programme should consider the developmental stage of the students as well as their social and cultural context. It references a number of resources that could be used.

¹¹³ Personal communication from the Department of Education and Science to the author on 6th July 2018.

Depending on what the school decides, students should continue to develop their knowledge and understanding about the reproductive system, family planning, personal integrity, sexually transmitted diseases, sexual harassment, gender orientation, sexual discrimination, personal rights and personal safety and loving relationship. Students should also learn about responsible decision making and explore the qualities of a loving, respectful relationship.

[Talking Relationships Understanding Sexuality Teaching Resource](#) (TRUST) contains a number of lesson plans that support the delivery of the RSE programme including contraception and decision-making. It is entirely at the discretion of the school and the SPHE department if it wishes to deliver on the topics.

The RSE Support Service and the SPHE Support Service (Post-Primary) were established in 1996 and 2000 respectively and a programme of continuing professional development (CPD) is provided to teachers. The SPHE Support Service is a partnership between the Department of Education and Skills, the Department of Health and Children and the Health Service Executive (HSE). Regional development officers (on secondment from schools to education centres) and health-promotion officers (from the HSE) provide school management and teachers with CPD workshops, group meetings and whole-school seminars on a range of SPHE themes.¹¹⁴ Thematic areas covered include substance use, bullying prevention and intervention, sexual orientation, and physical and emotional health.¹¹⁵

5.2 Reviews of RSE

Two years following the mandatory introduction of RSE in 1997, a national survey of primary and post-primary teachers, parents and schools found overwhelming support for school-based sexuality education, with teachers reporting a high level of satisfaction with the training they had received.¹¹⁶ Morgan also found, however, that notwithstanding a substantial increase in the percentage of schools that had finalised and circulated an RSE policy document between 1999 and 2000 (from 29% to 49.9%), there remained a substantial number of schools where little had been achieved, and an RSE policy committee had not been established in approximately 25% of schools.¹¹⁷

Between November 2004 and January 2006, Mayock, Kitching and Morgan undertook an assessment of the challenges to full implementation of RSE in the context of SPHE. In this study 66.6% of schools surveyed reported that RSE implementation levels had improved since its introduction.¹¹⁸ On closer scrutiny, however, while 60% of the schools surveyed reported that an agreed RSE policy statement was in place, 90% of schools surveyed had in fact delivered RSE, which suggested that a sizable proportion of schools were delivering RSE but without a policy.¹¹⁹

The [DES' Inspectorate's report of SPHE in 2013](#) (hereafter called 'the Inspectorate's evaluation') concluded that 96% of the schools inspected provided RSE for senior cycle students but there was significant variation in the quality of this provision, while only 56% of schools had an RSE policy in place, which suggests that there has been little progress in the development of RSE policies in the period between Mayock *et al*'s study and the Inspectorate's report.¹²⁰

¹¹⁴ Inspectorate, Department of Education and Skills, [Looking at Social, Personal and Health Education Teaching and Learning in Post-Primary Schools](#), 2013: 2

¹¹⁵ Ibid

¹¹⁶ Morgan, M. *Relationships and Sexuality Education: An Evaluation and Review of Implementation*. Dublin: Department of Education and Science (Dublin: 2000)

¹¹⁷ Mayock, P., Kitching, K., Morgan, M., [RSE in the context of SPHE: An Assessment of the Challenges to Full Implementation of the Programme in Post-primary Schools](#) (February 2007) p. 11

¹¹⁸ Ibid: 17

¹¹⁹ Ibid: 17

¹²⁰ Inspectorate, Department of Education and Skills, [Looking at Social, Personal and Health Education Teaching and Learning in Post-Primary Schools](#), 2013: 34

5.2.1 RSE resource materials

As indicated by Tables 5 and 6 above, RSE resource materials are not prescriptive and provide the teacher with options in relation to the delivery of the programme.¹²¹ The Junior Cycle SPHE Curriculum Framework sets out aims and learning outcomes for each module in each year of the programme. While schools have flexibility within the framework to order the topics according to school or class needs, it is intended that all content outlined in the framework will be covered. Mayock *et al*'s study highlighted that school autonomy allowed for the inclusion of a range of key topics, it also facilitated, they suggested, the potential exclusion of topics:

*At the very least, it can be legitimately argued that the absence of explicit directives and teaching resources for specific – and often sensitive – topics, such as homosexuality, means that students do not have equal opportunities for learning, discussion and debate on some aspects of sexuality.*¹²²

[Growing up Lesbian Gay Bisexual and Transgender \(LGBT\)](#) is a comprehensive resource for both SPHE and RSE developed by the DES, the Health Service Executive, BeLonG To Youth Services (Ireland's national organisation for LGBT+ young people) and GLEN (Gay and Lesbian Equality Network) in 2013. It aims to increase awareness and understanding about sexual orientation and gender identity and to reduce levels of prejudice and discrimination.¹²³ Notwithstanding this comprehensive resource, a *Budding Burning Issues* survey conducted among 13 to 24 year old LGBT+ young people, carried out as part of the 11th annual *Gay Community News Youth Issue* in association with BeLonG To in 2017, found that 39% complained of the absence of inclusive sex education in schools.¹²⁴

While schools are expected to deliver all elements of RSE, it appears that how materials and resources are used is determined by a number of factors:

- the school policy on RSE, as drawn up by the staff, principal, parents, board of management;
- existing provision for RSE in the school;
- RSE needs within the school, given the school's cultural context; and
- on-going evaluation of the strengths and weaknesses of the school's RSE programme.¹²⁵

Other criticisms of the RSE programme have emphasised the perceived failure to deal with a range of sensitive topics including masturbation,¹²⁶ while Kiely has claimed that the programme's focus on sexuality as a subject precludes an understanding of sex in pleasurable and desirable terms.¹²⁷

5.2.2 Quality of provision

The Inspectorate's evaluation, 2013 found that almost all of the schools were providing a programme of RSE for senior cycle students, but they identified significant variation in the quality of provision: RSE was found to be good or very good in 70% of schools evaluated but weaknesses outweighed strengths in 27% of schools.¹²⁸ Weaknesses included instances in which the RSE programme was limited solely to presentations made by external facilitators, with no follow-up

¹²¹ Mayock *et al*, 2007: 10

¹²² *Ibid*, 2007, p 11

¹²³ Department of Education and Skills, Health Service Executive, BeLonGTo and GLEN, [Growing up Lesbian Gay Bisexual and Transgender \(LGBT\): A Resource for SPHE & RSE](#), 2013

¹²⁴ Gay Community News, [70% of LGBT Young People Say Schools in Ireland are not Safe Places](#), Aidan Quigley 30th August 2017

¹²⁵ Mayock *et al*, 2007: 11

¹²⁶ Inglis, T., *Lessons in Irish Sexuality*. (Dublin: University College Dublin Press, 1998)

¹²⁷ Kiely, E., *Where is the discourse of desire? Deconstructing the Irish Relationships and Sexuality Education (RSE) resource materials*. *Irish Educational Studies*, 24, 2-3, 2005. pp 253-266.

¹²⁸ DES Inspectorate, 2013: 8

lessons to optimise students' learning. Other weaknesses include an absence of co-ordination between sex education classes and, for example, biological sciences and religious education. Furthermore, students commented on the lack of equity of provision due to timetabling arrangements that precluded senior cycle students from participation.¹²⁹

The Inspectorate reported that a core teaching team had been established in 63% of the school's sampled and noted that the presence of a core team was usually a good indicator of the quality of programme provision for senior cycle RSE. Where schools had not appointed a core team or an RSE co-ordinator, inconsistencies in the quality, breadth and balance of the programme were noted.¹³⁰ External facilitators supported senior cycle RSE in 41% of schools but in some schools the external support was the sole component of the RSE provided.¹³¹ Senior cycle students who met with the Inspectorate generally praised guest presentations but added that there needed to be scheduled time for follow up discussion. The evaluation concluded that, while external facilitators play a valued role, their role should only be supplemental to a school's RSE programme policy.¹³²

Mayock *et al* point to the limitations of methodological approaches that measure benchmarks like the presence or absence of an RSE policy as more qualitative approaches can uncover discrepancies in the quality and approach to implementation of the policy. Their case-study research, for example, uncovered significant variance in RSE delivery across the nine schools included in the study.¹³³ Mayock *et al* identified core characteristics along a continuum from low to high implementation that influence how RSE is both approached and delivered by schools – see Table 7. Parental involvement, teacher training and clarity, timetabling RSE within SPHE, and providing mechanisms that incorporate student perspectives appear to predict more qualitative learning outcomes.

5.2.3 Whole school support

Whole school support was also identified by Mayock *et al* as a core characteristic of RSE.¹³⁴ While almost all of the schools visited by inspectors in 2013 had a substance-use policy and an anti-bullying policy in place, 44% of schools did not have a whole-school RSE policy. This is necessary to provide staff with clear guidelines for the management and delivery of RSE.¹³⁵

5.2.4 Teacher training

Teacher training, clarity about themes and content and levels of comfort with teaching RSE were identified by Mayock *et al* as some of the core characteristics of RSE determining the quality of implementation.¹³⁶ While the deployment of teachers to SPHE was found to be good or very good by the Inspectorate's evaluation in 82% of the schools, there was scope for improvement of deployment practices in a minority of schools.¹³⁷

5.2.5 Programme planning

In almost half of the schools evaluated by the Inspectorate, practices and procedures that supported subject planning for senior cycle RSE tended not to be as effective as planning for SPHE. In 42% of schools included in the sample, the teachers of senior cycle RSE did not meet to formally discuss or review the quality of programme and in one third of schools (33%) there was no

¹²⁹ Ibid

¹³⁰ Ibid: 9

¹³¹ Ibid

¹³² Ibid

¹³³ Mayock *et al*, 2007: 19

¹³⁴ Ibid: 20

¹³⁵ DES Inspectorate, 2013: 8

¹³⁶ Mayock *et al*, 2007: 20

¹³⁷ DES Inspectorate, 2013: 12

co-ordinator of senior cycle RSE. The report noted that such practices had a negative impact on the quality of programme planning for RSE and led to inconsistencies in programme delivery.¹³⁸

In the Junior cycle, 79% of the programme corresponded with the Junior Cycle SPHE Curriculum Framework and incorporated topics from all of the ten modules.¹³⁹ Intended learning outcomes for each of the topics were omitted in over half of the programme plans.¹⁴⁰ Inspectors noted that only a small number of programme plans provided any information or guidance on the strategies that would be used to assess students' progress in SPHE lessons.

The Inspectorate reported that in 62% of schools there was evidence of weakness in the quality of programme planning, while students said that they would like more time allocated by their school to RSE. Furthermore, in 33% of schools sampled students expressed a desire for a broader RSE programme.¹⁴¹

5.2.6 Review of the RSE programme

On 3rd April 2018, Minister for Education and Skills, Richard Bruton T.D., announced a review of the RSE curriculum. The [National Council on Curriculum and Assessment \(NCCA\)](#) will co-ordinate the review. On 13th April 2018, the [Joint Committee on Education and Skills](#) invited written submissions from interested groups and individuals on its review of sexual health and relationship education including contraception, consent and related matters.

The NCCA review will consider the following issues specifically:

- Consent, what it means and its importance;
- Developments in contraception;
- Healthy, positive sexual expression and relationships;
- Safe use of the internet;
- Social media and its effects on relationships and self-esteem;
- LGBTQ+ matters.¹⁴²

¹³⁸ Ibid: 14

¹³⁹ Ibid: 15

¹⁴⁰ Ibid: 15

¹⁴¹ Ibid: 15-18

¹⁴² National Council for Curriculum Assessment, Review of Relationships and Sexuality Education. <https://www.ncca.ie/en/updates-and-events/consultations/review-of-relationships-and-sexuality-education-rse> [accessed 28th August 2018]

Table 4: Continuum of Implementation of Delivery of RSE in Post-primary Schools

Characteristic	Low level Implementation	High level Implementation
Co-ordination of SPHE/RSE	Low level co-ordination of SPHE within the school/sometimes no SPHE co-ordinator.	Appointed and committed SPHE co-ordinator who works with SPHE teachers and the entire staff to prioritise SPHE and RSE. The co-ordination of SPHE is designated a Post of Responsibility by the school management within the school.
Parental involvement	Little or no consultation with parents on the content of RSE or when formulating policy.	Parents consulted at the time of drawing up policy. Parents regularly informed about the content of RSE.
Status	Within the school community the value of SPHE/RSE is not recognised. The co-ordinator and teachers struggle in an atmosphere of ambivalence towards the subject.	SPHE/RSE is prioritised and valued by all staff members. The subject enjoys status in the planning of school 'business' generally and also among the students.
Teacher training	Few or no teachers trained while teaching SPHE/RSE, little awareness of training. Lack of access to extra training services.	A pool of well-equipped teachers using experiential learning methodologies for RSE. School provides additional funding for staff-wide training. Teachers using personal time to train in SPHE/RSE. High level of access to extra training services.
Teacher comfort	Virtual avoidance of RSE by teachers due to personal discomfort with the topic of sexuality. Lack of an RSE policy within school and a reluctance to use experiential learning methodologies. Fear of parental misgivings due to poor communication and lack of clarity on the matter of school ethos.	Positive confrontation of all RSE issues. Trained in facilitating openness and confidentiality amongst students. Personal level of confidence in negotiating any ethos issues. Supported by a clear RSE policy, school management and a clear and open relationship with parents.
Clarity among teachers about what can be taught	Teachers are extremely nervous about the topics they can 'safely' address and consequently avoid certain or all aspects of RSE teaching.	Teachers are confident about the boundaries of acceptability within RSE teaching and move comfortably through all aspects of the RSE programme in accordance with the school's RSE policy.
Student perspectives and understanding	Students feel that teachers are disinterested in and uncomfortable with RSE; they are dissatisfied with what is taught and are not accustomed to open discussion of relationships and sexuality. They are not consulted on RSE policy or the programme.	Students have confidence in their RSE teachers and enjoy RSE classes. They are reasonably or very satisfied with the programme content and generally feel comfortable and able to discuss relationships and sexuality. Students are consulted about RSE policy and the programme, possibly through the mechanism of the Students' Council.
Whole-school support	Lack of personal interest in RSE for many staff. Low level of communication and awareness around SPHE and RSE training and personal development. Major difficulties around teacher selected. Little or no parental involvement.	A large number of staff trained in SPHE/RSE. High level of openness and flexibility around RSE teaching and timetabling. Regular planning and evaluation of RSE progress, sharing of ideas and 'moral support'. Actively and explicitly outlining to parents how RSE is taught.

Source: Mayock *et al*, RSE in the context of SPHE, 2007: 20

6. Good Practice for Relationships & Sexuality Education¹⁴³

Chapter Summary

- There is clear evidence that school-based sex education programmes are effective in improving sexual health outcomes;
- School-based sex education is not enough by itself to prevent HIV and ensure the health and rights of young people but it is a cost-effective strategy;
- Young people who report lessons at school as their main source of information about sex are less likely to have had unsafe sex in the past year than young people who report receiving most of their information about sex from other (non-parental) sources;
- Abstinence-only programmes are not effective at promoting positive changes in sexual behaviour & young people report that they find abstinence approaches unrealistic;
- Multicomponent interventions that link school-based sexuality education with non-school-based youth-friendly health services are particularly effective;
- Young people want to learn about the risks but also the pleasures of sexuality;
- Students & professionals emphasise a 'sex-positive' approach to sex education that is frank and open, while acknowledging the diversity of sexual desire and emphasising consent;
- Some LGBTI students report feeling invisible within sexuality & relationships education;
- Findings from high-quality trials suggest that the most effective interventions are held in small groups, are multifaceted, interactive and with a variety of activities;
- Discomfort is sometimes reported in mixed-sex classes emphasising the need for good class control to ensure a safe environment;
- Sexuality education programmes are generally delivered by teachers, peers or health professionals, or a combination of all three: the characteristics of the instructor affects young people's acceptance and engagement with the programme;
- Programmes addressing gender or power are five times as likely to be effective in reducing crisis pregnancies and STIs;
- A companion resource & website to the RSE and SPHE specifically for parents and their children is recommended by a SH&CPA study;
- There is an association between frequent use of violent pornography and sexually aggressive attitudes among adolescent boys;
- One study interviewing 16-17 year olds in 39 schools in the London area found that the majority of young people (62.3%) and all teaching staff (100%) felt that schools should be teaching about the risks associated with viewing online sexually explicit media;
- In excess of one third of students in an NUIG study who were not in a relationship (n=240) said they would find it difficult or very difficult to tell a partner that a particular sexual activity was not making them feel good;
- People with disabilities have reported that while sexual information was acquired in school, from parents/family and media sources, pornography was cited by most participants as a primary source of information.

¹⁴³ Due to the time limitations placed on the production of this *Spotlight* it is not possible to undertake a systematic review of the evidence base for school-based sex education. As such, this section of the document is largely informed by two policy-transferable systematic reviews recently undertaken by reputable sources, as follows: 1) [Pound P, Denford S, Shucksmith J, et al. *What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views*. BMJ Open 2017;7:e014791. doi: 10.1136/bmjopen-2016-014791](https://doi.org/10.1136/bmjopen-2016-014791); and 2) [UNESCO. *Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention, Paris, UNESCO. \(2016\)*](https://doi.org/10.1136/bmjopen-2016-014791). The findings of these two reviews are sometimes complemented with additional relevant and topical research that is Irish-specific or published in the *Journal of Sex Education* in 2017 and 2018. The author has further identified five thematic areas not sufficiently explored by the systematic reviews upon which this good practice chapter is based. These are: the needs of **LGBTI**; people with **disabilities**; the issue of **consent**; **online pornography**, and the **role of parents** in supporting the delivery of school-based sex education

6.1 Introduction: A contested evidence-base

The evidence base for school-based sex education is contradictory and contested as outlined in the Introduction. On one hand, a synthesis of findings from five research packages and stakeholder consultations carried out by eight universities in the UK in 2016 concluded overwhelmingly that school-based sex education improves sexual health outcomes.¹⁴⁴ Furthermore, Montgomery and Knerr's (University of Oxford Centre for Evidence-based Interventions) systematic review for UNESCO in the same timeframe also concluded that sexuality education, whether it takes place in or outside a school setting, does not appear to increase sexual activity, sexual risk-taking behaviour or STI/HIV infection rates and that it "remains a crucial and cost-effective strategy".¹⁴⁵

On the other hand, however, health economic researchers from the Universities of Nottingham and Sheffield found a causal relationship between local authority expenditure cuts and small reductions in teen pregnancy in 2017, concluding that:

*...birth control will reduce the risk of pregnancy for sex acts which would have occurred anyway, but may increase the risk among teenagers who are induced by easier access to birth control either to start having sex or to have sex more frequently.*¹⁴⁶

The causal relationship between expenditure cuts at local authority level and reductions in teenage pregnancy is clearly apparent but the authors' conclusions should be interpreted with caution as this is only one study which found a very small reduction in teenage pregnancy. A Cochrane Database Systematic Review of school-based interventions for improving contraceptive use in adolescents found that the quality of the evidence was low and a lot of the studies were not comparable but they stopped short of deciding whether or not the evidence supports the effectiveness of school based sex education.¹⁴⁷ Another Cochrane Database Systematic Review published in 2016 examining school-based interventions for preventing HIV, sexually transmitted infections, and pregnancy in adolescents concluded that schools "may" be a good place in which to provide these services but that there is little evidence that educational curriculum-based programmes alone are effective in improving sexual and reproductive health outcomes for adolescents.¹⁴⁸

Mason-Jones *et al* and Montgomery and Knerr's systematic review for UNESCO point to the fact that sex education programmes alone will not offset other factors that have profound impacts on young people's sexual, reproductive and other health outcomes. Many factors combine together to affect the health of individuals and communities including genetics, socio-economic status, education, the physical environment, a person's social support network, and their individual characteristics and behaviours.¹⁴⁹ As such, sex education is unlikely to override or offset - without other supports and services – the determinants of health in general.

The contested nature of the evidence base creates a problem for policy makers who must make decisions about relationships and sexuality education policy and practice. Sexuality, however, is increasingly interpreted as a practice which is historically determined and related to both power

¹⁴⁴ Pound P *et al*, What is best practice in sex and relationship education? 2017: 8

¹⁴⁵ UNESCO. Review of the Evidence on Sexuality Education, 2016: 4

¹⁴⁶ Paton, D., Wright, L., *The effect of spending cuts on teen pregnancy*, Journal of Health Economics, Volume 54, July 2017, Pages 135-146

¹⁴⁷ Lopez LM, Bernholc A, Chen M, Tolley EE. School-based interventions for improving contraceptive use in adolescents. Cochrane Database of Systematic Reviews 2016, Issue 6. Art. No.: CD012249. DOI: 10.1002/14651858.CD012249.

¹⁴⁸ Amanda J Mason-Jones, David Sinclair, Catherine Mathews, Ashraf Kagee, Alex Hillman, Carl Lombard, School-based interventions for preventing HIV, sexually transmitted infections, and pregnancy in adolescents, Cochrane Database of Systematic Reviews, 2016

¹⁴⁹ World Health Organisation, Determinants of Health, <http://www.who.int/hia/evidence/doh/en/> [accessed 17th July 2018]

and societal values as outlined in the Introduction.¹⁵⁰ Previous chapters summarised Ireland's historical relationship with sex education in the State and the tensions that have evolved in the context of divergent values and ideological positions. However, the recent shift towards a liberal morally relativist approach as indicated by *Figure 1* is more closely aligned with the international policy architecture for school-based sex education, which favours a liberal and comprehensive approach for sex education in post-primary schools. Consequently, the good practice guidance presented here draws on two systematic reviews of the evidence base¹⁵¹ to present good practice for school-based sex education in the liberal tradition:

- The first of these is [Pound et al's](#) (2016)¹⁵² synthesis of findings from five research packages and stakeholder consultations carried out by eight universities in the UK in 2016. As this is a policy environment not significantly different to Ireland's, the lessons are likely to be transferable; and
- UNESCO's [Review of the Evidence on Sexuality Education](#)¹⁵³ which informed the update of the UNESCO International Technical Guidance on Sexuality Education and was undertaken by the [University of Oxford Centre for Evidence-Based Interventions](#) also in 2016.

The evidence from systematic reviews will be complemented by Irish-specific data where possible or more recent studies that enhance the core evidence. The author identified five additional areas not sufficiently well addressed by these systematic reviews including sex education specifically focused on the needs of **LGBTI**; people with **disabilities**; the issue of **consent**; **online pornography**, and the **role of parents** in supporting the delivery of school-based sex education. A rapid evidence assessment has been undertaken in each of these areas.

6.2 The school as provider of relationships and sexuality education

The evidence appears to suggest that schools are important sources of information about sex for young people. Pound *et al* found that the proportion of 16-year olds to 24-year-olds who reported that school lessons had been their main source of information about sex increased from 28% in 1990 to 40% in 2012 according to the UK's [National Survey of Sexual Attitudes and Lifestyles \(2012\)](#). The proportion of those who were dissatisfied with their level of knowledge about sex was lowest among those reporting that school had been their primary source of information. Unfortunately, the Irish-equivalent RSE programme was not sufficiently well embedded to measure any significant impact of school-based sex education when the [Irish Study of Sexual Health and Relationships \(ISSHR\) \(2006\)](#) was published by the Crisis Pregnancy Agency and the Department of Health. However, participants who had received sex education were asked to rate it (from all sources not only schools) in terms of how helpful it was in preparing them for adult relationships: 49% of men and 53.8% of women rated the sex education they received (from all sources) as helpful or very helpful. Montgomery and Knerr for UNESCO reported that while young people learn about sexuality and sexual health from many sources, schools still play a central role.¹⁵⁴ This review emphasises that school-based sexuality education is not sufficient in itself to prevent HIV or ensure the rights of young people to sexual and reproductive health, but programmes remain a cost-effective way to contribute to these aims.¹⁵⁵

¹⁵⁰ Saurteig, L and Davidson, R [eds] *Shaping Sexual Knowledge: A Cultural History of Sex Education in Twentieth Century Europe* (Routledge, 2008, p.1)

¹⁵¹ A systematic review is a robust summary of the results of independent studies and provides a high standard of research evidence pertaining to particular interventions, in this case school-based sex education

¹⁵² Pound P, Denford S, Shucksmith J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. *BMJ Open* 2017;7:e014791. doi: 10.1136/bmjopen-2016-014791;

¹⁵³ UNESCO. *Review of the Evidence on Sexuality Education*. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO. (2016).

¹⁵⁴ UNESCO, 2016:10

¹⁵⁵ Kivela, J., Ketting, E., & Baltussen, R. Cost analysis of school-based sexuality education programs in six countries. *Cost Effectiveness and Resource Allocation*, 2013. 11(1), 1-7. doi:10.1186/1478-7547-11-17

6.2.1 School-based RSE is associated with positive reported outcomes

The UK's the National Survey of Sexual Attitudes and Lifestyles (2012) indicates that young people who report lessons at school as their main source of information about sex are less likely to have had unsafe sex in the past year than young people who report receiving most of their information about sex from other (non-parental) sources. Pound *et al* reports that those who learn about sex mainly through school are more likely to be older at first intercourse and less likely to have had an STI. Women who have received most of their information about sex from school lessons are more likely to report feeling sexually competent when they first decide to have sexual intercourse. Sexual competence was defined by Pound *et al* as both partners being equally willing to engage in sexual intercourse, while using reliable contraception without the presence of alcohol or other drugs. Women who have experienced sex education in schools are also less likely to report having experienced rape, abortion or distress about sex.¹⁵⁶

6.2.2 Effectiveness of school-based or school-linked sexual health services

Sexual health services that are based in or linked to schools appear to reduce sexual activity, the number of sexual partners and teenage pregnancies¹⁵⁷. Professionals who participated in the interview study reported that better outcomes are observable when a school establishes links with local sexual health services.

Montgomery and Knerr's systematic review demonstrated that one of the most promising developments is multicomponent programmes that offer school-based sexuality education alongside community- or health-service-based services¹⁵⁸. Multicomponent interventions that link school-based sexuality education with non-school-based youth-friendly health services are particularly effective. One study reviewed three interventions in the UK and found that the intervention that included access to sexual health services reported more use of those services, including by young people from lower socioeconomic backgrounds with generally poorer sexual health outcomes.¹⁵⁹

6.3 Effectiveness of different sexuality and relationship education programmes

Pound *et al* suggests that comprehensive programmes (that aim to prevent, delay, cease or decrease sexual activity, while also promoting condom use and other safer sex strategies) can be effective at improving sexual knowledge and attitudes. HIV prevention programmes were found to be effective at improving knowledge, while pregnancy prevention programmes appear effective at improving knowledge and those targeting social disadvantage may reduce teenage pregnancies. Abstinence-only programmes were found to be not effective at promoting positive changes in sexual behaviour.¹⁶⁰

6.4 Professionals' and young people's views on different approaches to RSE

Pound *et al* report consensus among professionals and students that sex education should take place within a context that promotes a consistent set of values and principles.¹⁶¹ Then UK Education Secretary, Justine Greening, announced her intention in March 2017 to put RSE on a statutory footing. While retaining the right of withdrawal from sex education, with new rights for children to 'opt-in' as they approach age 16, Greening also indicated that schools would be

¹⁵⁶ Pound *et al*, 2016: 4

¹⁵⁷ *Ibid*

¹⁵⁸ UNESCO, 2016: 34

¹⁵⁹ Wight, D., The effectiveness of school-based sex education: What do rigorous evaluations in Britain tell us? *Education & Health*, (2011) 29(4), 72-78.

¹⁶⁰ *Ibid*

¹⁶¹ Pound *et al*, 2016: 4

permitted flexibility in their approach including faith-based schools to teach within the tenets of their faith.¹⁶²

6.4.1 Life skills approach

The UNESCO definition of school based sex education provided in Appendix B¹⁶³ operates a holistic view of sexuality and sexual behaviour, which goes significantly beyond traditional components of crisis pregnancy and HIV/STI prevention.¹⁶⁴ It seeks to embed positive values and attitudes towards sexual and reproductive health, and self-esteem, respect for human rights and gender equality.

Montgomery and Knerr's review for UNESCO emphasises that while the working definitions of school-based sex education differ, they tend to share grounding in human rights and empowerment, and particularly young people's rights to education about their bodies, relationships and sexuality.¹⁶⁵ Similarly, Pound *et al* identified consensus among professionals that good SRE should promote resilience and teach life skills, while they noted that young people wanted to learn refusal skills (see further discussion around consent below).¹⁶⁶

6.4.2 Risky behaviour approach

Topics such as sexual health and alcohol should be integrated into school-based sex education lessons. Almost half of young people participating in the UK's National Survey of Sexual Attitudes and Lifestyles (2012) reported that they wanted more information on risk reduction strategies. Pound *et al* identified in their qualitative synthesis, however, that young people do not appreciate sex education that emphasises all the risks without balancing with the pleasurable aspects of sexual intercourse. They further suggest that the evidence points to the need for educators to develop approaches to risk taking in consultation with young people.¹⁶⁷

6.4.3 Abstinence approach

There was consensus in Pound *et al*'s synthesis that many young people reported disliking an emphasis on abstinence within school-based sex education programmes, finding this focus unrealistic.¹⁶⁸ In systematic reviews of sexuality education, programmes focused on abstinence-only approaches tend to be fewer in number.¹⁶⁹

6.4.4. 'Sex-positive' approach

Students and professionals in the UK-based review of reviews favoured a 'sex-positive' approach to sex education referring to a programme that is frank and open, while acknowledging the diversity of sexual desire and emphasising consent. In the UK's National Survey of Sexual Attitudes and Lifestyles (2012), 20% of young men and 17% of young women wanted to learn more about the pleasurable aspects of sex. Young people also expressed a desire for more unbiased information about abortion, forms of contraception and the feelings that can accompany sexual activity.¹⁷⁰ Young people in the UK also commonly observed that school-based sex education often fails to consider female pleasure. Some also reported that lesbian, gay, bisexual and transgender students were invisible within sexuality and relationships education (see further discussion below).¹⁷¹ UNESCO emphasises that young people who do not conform to prevailing

¹⁶² House of Commons Library. [Briefing Paper: Relationships and Sex Education in Schools \(England\)](#). Number 06103, 23 August 2018

¹⁶³ UNESCO. International Technical Guidance on Sexuality Education: An Evidence-informed approach. Revised Edition. Paris, UNESCO. <http://unesdoc.unesco.org/images/0026/002607/260770e.pdf> (2018: 16)

¹⁶⁴ UNESCO, 2016: 7

¹⁶⁵ UNESCO, 2016: 7

¹⁶⁶ Pound *et al*, 2016: 4

¹⁶⁷ Ibid: 5

¹⁶⁸ Ibid: 5

¹⁶⁹ Fonner, V. A., Armstrong, K. S., Kennedy, C. E., O'Reilly, K. R., & Sweat, M. D. School based sex education and HIV prevention in low- and middle-income countries: a systematic review and meta-analysis. (2014) PLoS One, 9(3), e89692. doi:10.1371/journal.pone.0089692

¹⁷⁰ Pound *et al*, 2016: 5

¹⁷¹ Ibid

sexual and gender norms, including those who are lesbian, gay, bisexual or transgender are more vulnerable to violence in schools.¹⁷²

One author has found little evidence of infertility as a component of school-based sex education and yet infertility affects one in seven heterosexual couples in the UK.¹⁷³ Nargund advocates that sex education should encompass an examination of the factors that increase infertility including age-related infertility in men and women with treatment options including *in vitro fertilisation* (IVF).

6.4.5 Culturally and age-sensitive approaches

Young people in Pound *et al*'s qualitative synthesis reported that sex education can be culturally insensitive although some students from ethnic or religious minorities said that they value school-based sex education because such issues were not discussed within their own families.¹⁷⁴ The importance of age-appropriate information was also stressed by professionals.

6.5 Programme characteristics: sufficient duration and intensity

One strand of Pound *et al*'s review concluded that programmes should be of sufficient duration and intensity with professionals urging against the delivery of programmes that are concluded in one day.¹⁷⁵

6.5.1 Interactive and engaging

Programmes that employ interactive and participatory educational strategies tend to report higher participation rates and better learning outcomes.¹⁷⁶ Findings from high-quality trials suggest that the most effective school-based interventions are multifaceted, involving multiple sessions, that are interactive with a variety of activities.¹⁷⁷

6.5.2 Safe and confidential learning environments

Pound *et al*'s review concluded that programmes must create a safe environment for young people. Young people identified a need to participate fully without feeling ridiculed. Discomfort was sometimes reported in mixed-sex classes, with young men and women feeling vulnerable. Some young women and girls expressed a preference for single-sex classes all or some of the time, but young men appeared to want mixed-sex classes. Professionals and young people reported that good class control is essential for ensuring a safe environment. Building trust between classmates could increase engagement in classes, while instructors must ensure that there are ground rules (for discussion, behaviour and confidentiality).¹⁷⁸

6.6 Who should deliver school-based sex education?

In Pound *et al*'s study young people reported that good sex educators seem to enjoy teaching sex education, have experiential knowledge and are comfortable with their own sexuality. Sex educators are:

professional, confident, unembarrassed, straightforward, experienced at talking about sex and use everyday language.... [they are] specifically trained in SRE [sexuality and relationships education], are trustworthy, approachable, non-judgemental and able to maintain confidentiality. They

¹⁷² UNESCO, 2018: 23

¹⁷³ NICE guidance (CG156) 2013.

¹⁷⁴ Pound *et al*, 2016: 5

¹⁷⁵ *Ibid*: 6

¹⁷⁶ *Ibid*

¹⁷⁷ Lopez, L. M., Bernholc, A., Chen, M., & Tolley, E. (2016). School-based interventions for improving contraceptive use in adolescents. The Cochrane Library. doi:10.1002/14651858.CD012249

¹⁷⁸ Pound *et al*, 2016: 6

*respect young people and their autonomy, treat young people as equals and accept that they may be sexually active.*¹⁷⁹

Sexuality education programmes are generally delivered by teachers, peers or health professionals, or a combination of all three.¹⁸⁰ Shepherd *et al* found that the characteristics of the instructor affected young people's acceptance and engagement with the programme.¹⁸¹

6.6.1 School teachers and teacher training

Most professionals in Pound *et al*'s interview study suggested that good practice involves a partnership between teachers and others, including school nurses or experts. Young people, however, tended to regard school teachers as unsuitable for delivering sex education and perceived that they were embarrassed or unable to discuss sex frankly and openly. They also pointed to discomfort and awkwardness in discussing such issues with a school teacher they had an ongoing relation with. Additionally some young people pointed to the power imbalance inherent in the teacher-pupil relationship which can prove problematic in the context of sex education.¹⁸² These same issues are also emphasised by the UNESCO systematic review of evidence for sex education pointing to the need for a comprehensive programme of teacher training and support¹⁸³.

6.6.2 Sexual health professionals

The review of the evidence for school-based sex education recommended that UNESCO's revised technical guidance (2018) needed to address difficult or sensitive issues.¹⁸⁴ This review placed strong emphasis on the emotional impact of sex education on students and teachers. The evidence suggests that those who deliver sex education programmes must be well trained and competent to deal with sensitive issues including, for example, harmful practices or norms. They also recommend engaging external sexual health professionals. Pound *et al*'s interviews with students found that external experts are perceived to be less judgemental and preferred to teachers because they are perceived to provide greater confidentiality and reduce embarrassment but problems of discipline were also reported.¹⁸⁵

6.6.3 Peer educators

Montgomery and Knerr for UNESCO concluded that there is limited evidence of effectiveness for peer-led sex education programmes compared to those that are led by teachers.¹⁸⁶ Pound *et al*, however, found that young people reported a sense of affinity with their peers and found other young people to be credible educators, although one arm of the study found that credibility is sometimes undermined by lack of knowledge.¹⁸⁷

6.7 Factors to consider when developing new sex education programmes

Pound *et al*'s review and their interview study concluded that sex education programmes need to be developed with input from key stakeholders including young people themselves. Programme evaluations should also include young people and the study authors recommended that there needs to be short and long-term health outcome measures used.¹⁸⁸ They also need to be carefully planned using logic models in order to support effective monitoring and evaluation. Professionals consulted as part of this study also advocated programmes that are tailored to local needs and

¹⁷⁹ Pound *et al*, 2016: 6

¹⁸⁰ Fonner, V.A., School based sex education and HIV prevention in low- and middle-income countries: (2014)

¹⁸¹ Shepherd, J., Kavanagh, J., Picot, J., Cooper, K., Harden, A., Barnett-Page, E., . . . Price, A., The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: A systematic review and economic evaluation. Health Technology Assessment, 2010. 14(7), 1-230.

¹⁸² Pound *et al*, 2016: 6-7

¹⁸³ UNESCO, 2016: 5

¹⁸⁴ UNESCO, 2016: 4

¹⁸⁵ Pound *et al*, 2016: 7

¹⁸⁶ UNESCO, 2016: 4

¹⁸⁷ Pound *et al*, 2016: 7

¹⁸⁸ Pound *et al*, 2016: 7

congruent with the values of the school.¹⁸⁹ Pound and colleagues also found that when fidelity¹⁹⁰ is compromised, key messages can be lost or interpreted by individual values and perspectives. While a range of other factors can also impact on programme implementation including funding, staff capacity or government policies, Montgomery and Knerr for UNESCO also emphasise the importance of dedicating resources to ensuring fidelity of implementation.¹⁹¹

In considering the development of sex education programmes, UNESCO's review emphasises that at national and international levels, sex education programmes must encompass explicit human-rights, life skills and an empowerment focus. Expert consultations have also stressed the need for an empowerment approach that is explicitly focused on gender and power:

*...sexuality education seeks explicitly to empower young people — especially girls and other marginalized young people — to see themselves and others as equal members in their relationships, able to protect their own health, and as individuals capable of engaging as active participants in society.*¹⁹²

There is increasing awareness of the need to increase the engagement of young men in preventing teenage pregnancy.¹⁹³ One Northern Ireland study tested the effectiveness of a teacher-delivered intervention which focused explicitly on the role of young men in preventing an unintended pregnancy. The intervention involving 831 pupils (mean age 14) in schools throughout Northern Ireland took place with the involvement of young women and reported significantly lower incidences of unprotected sex in the intervention group compared to the control group.¹⁹⁴ The study concluded that such an intervention is culturally sensitive and flexible enough to facilitate faith-based schools¹⁹⁵ and acceptable in mixed-sex schools in the UK.¹⁹⁶

Haberland's comprehensive analysis of evaluation studies found that programmes addressing gender or power were five times as likely to be effective as those that did not.¹⁹⁷ Almost 80% were associated with a significantly lower rate of STIs or unintended pregnancy, whereas only 17% of those that did not address either gender or power in relationships reported such an association.¹⁹⁸ Notwithstanding these findings, Montgomery and Knerr found little evidence that an empowerment approach to sexuality is implemented widely.¹⁹⁹

The research evidence pointing to key components of sex education programming was identified by Kirby, Laris & Rollieri in 2006 and has not been replaced or updated. The core characteristics of sex education programming remain:

¹⁸⁹ A Logic Model or Framework is a visual diagram that illustrates how a programme will work. It is a tool used to evaluate the effectiveness of a programme.

¹⁹⁰ Implementation fidelity refers to the degree to which an intervention or programme is delivered as intended.

¹⁹¹ UNESCO, 2016: 5; Pound, P., Langford, R., & Campbell, R., What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *BMJ Open* 6(9) 2016. doi:10.1136/bmjopen-2016-011329

¹⁹² Haberland, N., & Rogow, D., Sexuality Education: Emerging Trends in Evidence and Practice. *Journal of Adolescent Health*, 56(1), S15-21. 2015: 16 doi:10.1016/j.jadohealth.2014.08.013

¹⁹³ World Health Organisation. [Maternal, newborn, child and adolescent health](#). 2018.

¹⁹⁴ Lohan, M., Aventin, A., Clarke, M., Curran, R., McDowell, C., Agus, A., ... Young, H. Can teenage men be targeted to prevent teenage pregnancy? A feasibility cluster randomised controlled intervention trial in schools. *Prevention Science*, 2018. 1-12. DOI: 10.1007/s11121-018-0928-z

¹⁹⁵ Lohan M, Aventin A, Clarke M, Curran R, McDowell C, Agus A, ... Young, H. Can teenage men be targeted to prevent teenage pregnancy? A feasibility cluster randomised controlled intervention trial in schools. *BMJ Open* 2018;8:e022128. doi:10.1136/bmjopen-2018-022128

¹⁹⁶ Lohan, M., Aventin, A., Clarke, M., Curran, R., McDowell, C., Agus, A., ... Young, H. Can teenage men be targeted to prevent teenage pregnancy? A feasibility cluster randomised controlled intervention trial in schools. *Prevention Science*, 2018. 1-12. DOI: 10.1007/s11121-018-0928-z

¹⁹⁷ Haberland, Nicole A. "The Case for Addressing Gender and Power in Sexuality And HIV Education: A Comprehensive Review Of Evaluation Studies." *International Perspectives On Sexual & Reproductive Health* 41, no. 1 (March 2015): 31-42. Academic Search Premier, EBSCOhost (accessed August 9, 2018).

¹⁹⁸ Haberland, Nicole A. "The Case for Addressing Gender and Power in Sexuality And HIV Education: A Comprehensive Review Of Evaluation Studies." *International Perspectives On Sexual & Reproductive Health* 41, no. 1 (March 2015): 31-42. Academic Search Premier, EBSCOhost (accessed August 9, 2018).

¹⁹⁹ UNESCO, 2016: 11

1. to focus on clear health goals — the prevention STI/HIV and/or crisis pregnancy;
2. to focus on specific behaviours leading to these health goals;
3. to address multiple sexual psychosocial risk and protective factors affecting sexual behaviours (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy);
4. to create a safe social environment for youth to participate;
5. to include multiple activities to change each of the targeted risk and protective factors;
6. to employ instructionally sound teaching methods that actively involve participants;
7. to include activities, instructional methods and behavioural messages that are appropriate to the youths' culture, developmental age, and sexual experience;
8. to cover topics in a logical sequence.²⁰⁰

Lopez, Bernholc, Chen and Tolley (2016) found in a rigorous review of interventions, however, that many trials do not report the content or key characteristics of interventions and as such, the evidence base for core content is weakened by this oversight.²⁰¹

Pound *et al*'s study of young people's experience of sex education in the UK, Ireland, the USA, Australia, New Zealand, Canada, Japan, Iran, Brazil and Sweden found that the following topics are either not addressed sufficiently well or at all:

1. Pros and cons of different types of contraception;
2. Emergency contraception and its adverse effects;
3. Different opinions on contraceptive pill, adverse effects of contraceptive pill;
4. Contraceptives other than the condom;
5. Where to obtain different forms of contraception, how to buy condoms;
6. What to do if no contraception is available;
7. Why condoms should be used;
8. How to use male and female condoms; importance of lubrication;
9. Pregnancy options, i.e., adoption, abortion, teenage pregnancy;
10. Unbiased information on abortion and how to deal with an abortion;
11. STIs, including transmission through oral sex.²⁰²

Pound *et al* also found inadequate and ineffective delivery across countries and over time in the review of young people's experiences and highlighted the importance of paying attention to fidelity of implementation.

Finally, Pound *et al*'s consultation with professional stakeholders pointed to the importance of age-appropriate sex education that spans the compulsory school cycle. Experts also recommended that parents are proactively engaged in the programme. Stakeholders further recommended programmes that mix sexes and are teacher-led, while acknowledging that young people can feel vulnerable in mixed classes and report a level of discomfort with familiar teachers. It is suggested that these challenges may be overcome by teacher training.²⁰³

On the basis of their extensive literature review and comprehensive consultations with professional stakeholders and students, Pound *et al* have developed characteristics for good practice in sex education (see Table 8)

²⁰⁰ Kirby, D., Laris, B., & Roller, L. The impact of Sex and HIV Education Programs in Schools and Communities on Sexual Behaviors Among Young Adults Research Triangle Park, NC: Family Health International. 2016: 213. Retrieved from <http://www.sidastudi.org/resources/inmagic-img/dd1054.pdf>.

²⁰¹ Lopez, L. M., Bernholc, A., Chen, M., & Tolley, E. (2016). School-based interventions for improving contraceptive use in adolescents. The Cochrane Library. 2016: doi:10.1002/14651858.CD012249

²⁰² Pound, P., Langford, R., & Campbell, R., What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. BMJ Open 6(9) 2016: 10 doi:10.1136/bmjopen-2016-011329

²⁰³ Pound *et al*. 2016:7

6.8 Lesbian, gay, bisexual, transgender and intersex (LGBTI) young people²⁰⁴

UNESCO's guidance for sex education published in 2018 highlights the paucity of research on LGBTI young people's sexual and reproductive needs.²⁰⁵ It points to the fact that sexuality education programmes tend to omit relevant content for LGBTI populations and argue that key stakeholders – parents and teachers, educational institutions and policymakers – have a role to play in changing that.²⁰⁶ [Growing Up LGBT: A Resource for SPHE and RSE](#) was developed by the Department of Education and Skills and the Health Service Executive through the Social, Personal and Health Education Support Service, in collaboration with BeLonG To Youth Services and GLEN (Gay and Lesbian Equality Network) in 2013 but delivery has been *ad hoc* and piecemeal as outlined in the previous chapter. As outlined above, Pound *et al*'s qualitative synthesis of research found that young people commonly complained that school-based sex education is “gendered and heterosexist” with some reporting that lesbian, gay, bisexual and transgender students are largely invisible in sex education programming.²⁰⁷

6.9 The Role of Parents

As outlined in Chapter 2, Bunreacht na hÉireann recognises the rights of parents as the primary educators of their children in Article 42.1. One of the limitations of Pound *et al*'s otherwise comprehensive study is that the views of parents are not captured but they nonetheless recognise the importance of parental involvement in supporting both the planning and delivery of sex education at the level of the school.²⁰⁸ The [Sexual Health and Crisis Pregnancy](#) programme commissioned a study to explore the factors that both enable and inhibit age-appropriate communication between parents and young children aged 4 to 9 years about relationships, sexuality and growing up. [Conlon *et al*](#) reported that parents of children aged 4 to 9 years hoped that talking with their children from a young age would help to normalise their perception of the body, sexuality and relationships. In focus group discussions and follow-up telephone interviews, parents identified a need to ‘work on themselves’ so that they could feel comfortable about their own body and sexuality and to counter the taboos they had experienced growing up in Ireland.²⁰⁹ Some parents used anatomical names instead of euphemisms to refer to sex organs and genitalia, but others found this too harsh for small children: a higher proportion of parents found the use of anatomical terms for a female body more difficult, which Conlon suggests may be due to the female body being subject to more cultural taboos.²¹⁰

Parents did not appear to use many specific resources to help them communicate with their children and while the internet provides significant resources, concerns were expressed by study participants with regard to the quality and provenance of materials.²¹¹ Consequently, parents were more inclined to wait for their children to ask questions rather than initiating proactive communication.

While some parents questioned the approach taken by schools, many were happy to follow the school curriculum in communicating with their children. The core benefit of school-based SPHE identified by parents is the age-appropriate standardisation of learning, which appears to mitigate parental concern about breaching the communication boundaries of other parents. Parents who struggled to find a language through which to communicate with their children largely welcomed the guidance of the school curriculum.²¹²

²⁰⁴ For definitions of these terms please see Appendix B

²⁰⁵ UNESCO, 2018: 31

²⁰⁶ *Ibid*: 86

²⁰⁷ Pound *et al*. 2016:5

²⁰⁸ *Ibid*: 8

²⁰⁹ Conlon, C. [Supporting Parents Communicating with Children Aged 4–9 Years about Relationships, Sexuality and Growing Up](#) (With contributions from Virpi Timonen and Georgia Dowling). (Sexual Health and Crisis Pregnancy Agency: Dublin) 2018:

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²¹⁰ *Ibid*, 2018:97

²¹¹ *Ibid*, 2018: 98

²¹² *Ibid*, 2018: 99

Conlon *et al*'s study recommended that a companion resource and website to the RSE and SPHE specifically for parents and their children should be developed, with an awareness campaign that would aim to help drive change for greater openness between younger children and parents. The study's authors also called for schools to strengthen RSE to enable the conversation begun in the classroom to be continued at home.²¹³

An [earlier study \(2009\)](#) also commissioned by the Crisis Pregnancy Agency attempted to understand how parents communicate on the topic of relationships and sexuality with their pre-adolescent and adolescent children. This study found that the majority of parents approached the subject of sexuality by a range of routes: child-initiated questions, text-based materials and opportunistic communication. In pre-adolescent years children appeared more likely to raise the subject but in adolescence parents initiated communication. The study found that there was greater openness to talking about sex among parents from lower socio-economic groups.²¹⁴

While parents described a culture of openness within their homes, the study found that free, open and uninhibited discussion between parents and adolescents was not described by any participant.²¹⁵ The majority of parents were not inclined to believe that their children younger than 18 years may be sexually active, although mothers from lower socio-economic groups were more open to the possibility that their teenage children may be sexually active.²¹⁶

Researchers noted a general air of "vagueness" about the content of sexuality education in secondary school with most parents advocating complementary roles for parents and the school.²¹⁷ The study concluded that parents need to recognise their responsibility to talk to their children about relationships and sexuality, and that school RSE and SPHE programmes should encourage young people to speak to their parents. The study's authors recommended increased liaison between schools and parents, while at community level they advocated the development of strategies to raise awareness among parents of the strengths and weaknesses of their approaches to communicating with their children.²¹⁸

²¹³ Ibid, 2018:101

²¹⁴ Hyde, A., Carney, M., Drennan, J., Butler, M., Lohan, M., Howlett, E. [Parents' Approaches to Educating their Pre-adolescent and Adolescent Children about Sexuality](#). Crisis Pregnancy Agency. July 2009

²¹⁵ Hyde *et al*, 2009: 14

²¹⁶ Hyde *et al*, 2009: 15

²¹⁷ Hyde *et al*, 2009: 15

²¹⁸ Hyde *et al*, 2009: 21-22

Table 5: Characteristics of Good Practice in RSE²¹⁹**Sexual health and advice services**

- **RSE programmes should involve close liaison with relevant sexual health and advice services, either through school-based services or through links with local sexual health services.**

SRE²²⁰ curriculum model

- **RSE should be appropriate for pupils' culture, age and sexual experience. It should start in primary school and use age-appropriate language, topics and activities.**
- **RSE should continue throughout the period of compulsory schooling, ideally up to age 18.²²¹**
- **RSE programmes should be of sufficient duration and intensity; that is teaching should be delivered via regular lessons, as well as special projects and events. 'Drop down days' are only acceptable if they supplement an ongoing programme, not if they constitute the only SRE provision within a school.**
- **RSE curricula should be adaptable and flexible, and identify core and peripheral features.**
- **RSE programmes should use a spiral curriculum model, exploring topics in logical sequence and avoiding inappropriate repetition.**
- **Educators should employ a diverse range of interactive and participatory educational strategies that actively engage recipients.**
- **Schools should take a proactive approach to engaging parents about RSE.**

SRE content

- **Bearing in mind age appropriateness, RSE should be 'sex-positive'; that is, it should be open, frank and informative, and should acknowledge the pleasure of sex. It should reflect that some young people are sexually active and acknowledge young people's autonomy and level of maturity. It should not focus on abstinence.**
- **RSE should reflect sexual diversity. It should discuss a range of sexual activity (not just heterosexual intercourse), as well as lesbian, gay, bisexual and transgender relationships.**
- **RSE should include teaching on consent, sexting, cyberbullying, online safety, sexual exploitation and sexual coercion.**
- **RSE should challenge, rather than reinforce, gender stereotypes and inequalities.**
- **RSE should be culturally sensitive.**
- **RSE should be integrated into a 'whole school' ethos and should teach life skills (e.g. planning, decision-making skills), specific skills (e.g. communication, sexual negotiation skills) and promote resilience.**
- **RSE should provide impartial information on contraception, safer sex, pregnancy and abortion.**
- **RSE should discuss relationships and emotions.**
- **Where appropriate, potentially risky practices should be considered in combination, for example considering the risks of sexual activity alongside substance use.**
- **Lessons on the risks of sexual activity need to be developed carefully; an overemphasis on risk can alienate some young people, particularly if the risks are emphasised at the expense of the positive and pleasurable aspects of sex.**
- **RSE programmes should be developed with input from young people.**

SRE delivery

- **RSE should take place in a safe environment for young people. This necessitates excellent class control and protection of students from harassment.**
- **Teaching should be delivered in small groups where appropriate and in single-sex groups at least some of the time. Primary school children may feel more comfortable in single-sex classes.**
- **RSE should take place in a confidential environment. Distancing techniques should be used with caution to avoid student disengagement. Young people's trust in confidentiality is enhanced by the educator's separateness from the school.**
- **Staff delivering RSE should be trained educators, have expertise in sexual health, be sex-positive and enthusiastic about delivering RSE.**
- **External sexual health professionals should be involved in delivering RSE.**
- **School teachers should be willing to work in partnership with health professionals.**
- **Ideally staff delivering RSE to secondary school²²² pupils will not be in an ongoing relationship with students in another capacity (i.e. will not be familiar to students as form or subject teachers). This is to protect student confidentiality, privacy and boundaries.**
- **Trained peer educators have a role to play in delivering RSE, in partnership with experts.**

²¹⁹ Source: *adapted from* Pound P, Denford S, Shucksmith J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. *BMJ Open* 2017;8:e01479

²²⁰ SRE = Sexuality and Relationships Education, the term used in the United Kingdom for RSE.

²²¹ This criterion comes from stakeholder consultations; it does not constitute research evidence.

²²² Stakeholder consultations suggest that primary school-aged children might feel more comfortable with familiar teachers; however, this is only suggestive and does not constitute research evidence.

6.10 Online Pornography

New technology has made pornography easily accessible and there is a growing evidence base that has identified a relationship between viewing pornography and violent or abusive behaviour in young men.^{223 224} School-based sex education programmes provide the means through which intimate partner violence is addressed in both the United States (dating violence programs) and the United Kingdom (Personal, Social and Health Education).²²⁵ One non-systematic review identified an association between frequent use of violent pornography and sexually aggressive attitudes among adolescent boys²²⁶, while another review suggested that aspects of brain development in adolescence when coupled with limited experience of intimate relationships may render young people particularly vulnerable to adverse effects.²²⁷ A general population study of 14-19 year olds in Italian schools found a significant association between viewing pornographic material and pornographic films and videos and active harassment and perpetration of forced sex.²²⁸ A Swedish study found that that young Swedish men who viewed violent pornography were more likely to demonstrate sexually coercive behaviour in their relationships than the control group, while the same study also noted that young women who viewed violent pornography were more likely to have sold sex or have peers who watch it.²²⁹

Stanley *et al* surveyed 4,564 young people between the ages of 14 and 17 years in five European countries (Bulgaria, Cyprus, England, Italy and Norway) and found that between 19% and 30% of young people across countries regularly viewed pornography.²³⁰ Reflecting similar findings in this field of research,²³¹ boys were significantly more likely than girls to view pornography and girls were more likely to experience sexual coercion. Rates of sexual coercion by boys were particularly high in England and Italy, which was found to be consistent with victim reports of intimate partner violence in these countries. Boys were more likely to describe the use of 'pressure' rather than 'force' with 34% of boys responding to the survey in Italy admitting to pressuring a partner into kissing, intimate touching, or intercourse.²³²

Similar proportions of adolescent girls (between 9% and 49%) and a slightly higher proportion of adolescent boys (20% to 47%) reported receiving a sexual image. This occurred in all countries and was described as a reciprocal activity with two-thirds of young people who sent an image reporting that they had received one. The highest rates for both sending and receiving a sexual image were in England and Cyprus. Young people who had experienced intimate partner violence in this study were twice as likely to have sent or received a sexual image as those who had not experienced intimate partner violence.

Negative attitudes to women were also found to be associated with online pornography demonstrating that both the frequency and explicitness of pornography can reinforce a belief that women are sex objects.²³³

²²³ Stanley, N., Ellis, J., Farrelly, N., Hollinghurst, S., & Downe, S. Preventing domestic abuse for children and young people: A review of school-based interventions. *Children and Youth Services Review*, 2015. 59, 120-131;

²²⁴ Baker, Karen Elizabeth. 2016. "Online pornography – Should schools be teaching young people about the risks? An exploration of the views of young people and teaching professionals." *Sex Education* 16, no. 2: 213-228. Academic Search Complete, EBSCOhost (accessed August 23, 2018).

²²⁵ Stanley, N., Ellis, J., Farrelly, N., Hollinghurst, S., & Downe, S. Preventing domestic abuse for children and young people: A review of school-based interventions. *Children and Youth Services Review*, 2015. 59, 120-131.

²²⁶ Flood, M. The harms of pornography exposure among children and young people. *Child Abuse Review*, 2009, 18, 384-400.

²²⁷ Owens, E. W., Behun, R.J., Manning, J. C., & Reid, R. C. (2012). The impact of internet pornography on adolescents: A review of the research. *Sexual Addiction & Compulsivity: The Journal of Treatment & Prevention*, 19, 99-122.

²²⁸ Bonino, S., Ciairano, S., Rabaglietti, E., & Cattelino, E. (2006). Use of pornography and self-reported engagement in sexual violence among adolescents. *European Journal of Developmental Psychology*, 3, 265-288.

²²⁹ Kjellgren, C., Priebe, G., Svedin, C. G., & Langstrom, N. (2010). Sexually coercive behavior in male youth: Population survey of general and specific risk factors. *Archives of Sexual Behavior*, 39, 1161-1169.

²³⁰ Stanley, Nicky, Christine Barter, Marsha Wood, Nadia Aghtaie, Cath Larkins, Alba Lanau, and Carolina Överlien. 2016. "Pornography, Sexual Coercion and Abuse and Sexting in Young People's Intimate Relationships: A European Study." *Journal Of Interpersonal Violence* MEDLINE, EBSCOhost (accessed August 23, 2018).

²³¹ Horvath, M. H. A., Alys, L., Massey, K., Pina, A., Scally, M., & Adler, J. R. (2013). "Basically. . . porn is everywhere." A rapid evidence assessment on the effect that access and exposure to pornography has on children and young people. London, England: Children Commissioner's Office. Retrieved from http://www.childrenscommissioner.gov.uk/content/publications/content_667

²³² Stanley *et al*, Pornography, Sexual Coercion and Abuse, 2016: 2929-2936

²³³ Ibid; Peter, J., and P. M. Valkenburg. "Adolescents' Exposure to a Sexualized Media Environment and

Reflecting the conclusions of earlier researchers,²³⁴ this European study found that regular exposure to online pornography is both a common and serious risk for children.²³⁵ Some researchers have argued that pornography offers an approach to learning about sexual performance, which tends not to be included in formal school-based sex education programming.²³⁶ Stanley *et al* do not concur with this assessment concluding that “pornography’s value as a tool for sex education is undermined by its sexism and misogyny, which have the potential to inform sexually coercive and abusive behaviour in young men.”²³⁷ Steps to reduce access to pornography given its pervasive nature are less likely to be successful than steps which incorporate discussions about online pornography into sex education programming.

One study which interviewed 16-17 year olds in 39 schools in the London area found that the majority of young people (62.3%) and all teaching staff (100%) felt that schools should be teaching about the risks associated with viewing online sexually explicit media.²³⁸ These students expressed a preference for peer-led followed by teacher-led discussions in small groups. Teachers who participated in this study considered there to be more negative than positive effects to viewing online pornography particularly that it was normalising behaviours between young boys and girls. While 76.8% of young people reported that they did not think pornography was a realistic representation of typical sexual relationships, teachers were sceptical about young people’s capacity to view pornography critically.²³⁹

Finally, an Australian study also identified that young people are frequently intentionally and unintentionally exposed to pornography, which they found linked to young men’s sexual expectations and young women’s pressure to conform to content viewed online. This study also concludes that a space needs to be created for young people to challenge the messages expressed in pornography.²⁴⁰

6.11 Consent

In Pound *et al*’s study, young people highlighted the need for sex education content to include teaching on consent, sexting, cyberbullying, online safety, sexual exploitation and sexual coercion.²⁴¹

There is a general paucity of research evidence responding to the issue of consent in school-based sex education programmes but the [Smart Consent initiative](#)²⁴² was developed in 2013 in the National University of Ireland, Galway (NUIG). It is a study of how college students speak about sexual consent and non-consent and was conducted with the support of Rape Crisis Network

Their Notions of Women as Sex Objects.” *Sex Roles* 2007 56: 381–395.

Peter, J., and P. M. Valkenburg. “Adolescents’ Exposure to Sexually Explicit Internet Material and Notions of Women as Sex Objects: Assessing Causality and Underlying Processes.” *Journal of Communication* 2009. 59: 407–433.

²³⁴ Livingstone, S., Haddon, L., Görzig, A., & Olafsson, K. (2011). *Risks and safety on the internet: The perspective of European children. Full findings*. London, England: London School of Economics/EU Kids Online.

²³⁵ Stanley *et al*, *Pornography, Sexual Coercion and Abuse*, 2016: 2929-2936

²³⁶ Rothman, E. M., Kaczmarzky, C., Burke, N., Jansen, E., & Baughman, A. “Without porn . . . I wouldn’t know half the things I know now”: A qualitative study of pornography use among a sample of urban, low-income, black and Hispanic youth. *Journal of Sex Research*, 2015. 52, 736-746. doi:10.1080/00224499.2014.960908; Smith, M. Youth viewing sexually explicit material online: Addressing the elephant on the screen. *Sexuality Research and Social Policy*, 2015, 10, 62-75.

²³⁷ Stanley *et al*, *Pornography, Sexual Coercion and Abuse*, 2016: 2940

²³⁸ Baker, Karen Elizabeth. 2016. “Online pornography – Should schools be teaching young people about the risks? An exploration of the views of young people and teaching professionals.” *Sex Education* 16, no. 2: 213-228. Academic Search Complete, EBSCOhost (accessed August 23, 2018).

²³⁹ Baker, Karen Elizabeth. 2016. “Online pornography – Should schools be teaching young people about the risks? An exploration of the views of young people and teaching professionals.” *Sex Education* 16, no. 2: 213-228. Academic Search Complete, EBSCOhost (accessed August 23, 2018).

²⁴⁰ Higgs, Peter, Meredith Temple-Smith, Shelley Walker, Peter Higgs, Meredith Temple-Smith, and Lena Sanci. 2015. “It’s always just there in your face’: young people’s views on porn.” *Sexual Health* 12, no. 3: 200-206. Science Citation Index, EBSCOhost (accessed August 23, 2018).

²⁴¹ Pound *et al*, 2016: 7

²⁴² MacNeela, P., Breen, J., Byrnes, E., O’Higgins, S., Seery, C., Silke, C. Development, Implementation, and Evaluation of the SMART Consent Workshop on Sexual Consent for Third Level Students. Irish Research Council, National University of Ireland, Galway, Health Service Executive, Confederation of Student Services in Ireland. (undated)

Ireland. The resulting report '[What's Consent Got to Do With It](#)'²⁴³ (MacNeela et al., 2014) examined how students discussed sexual consent. A synthesis of research findings from the initiative during 2016-2017 provided new insights into the attitudes, beliefs, and experiences of third level students in terms of sexual consent.

On the subject of school-based sex education the authors noted that being comfortable enough to talk about consent with a partner arises in the context of previous opportunities to learn about sexual communication. MacNeela *et al* found that 29% of students agreed that their sexual health education in school covered issues that they were interested in, while 65% thought their sexual health education at school had been inadequate. Twenty per cent of the study sample indicated they had learned most of what they knew about sexual health from school, which suggests that the vast majority – 80% - acquired their knowledge about sexual health elsewhere.²⁴⁴ In excess of one third of the participants who were not in a relationship (n=240) said they would find it difficult or very difficult to tell a partner that a particular sexual activity was not making them feel good. Twenty per cent of students who were in a relationship (n=237) said they would not feel comfortable communicating that a particular sexual activity was not making them feel good.²⁴⁵

While this study is undertaken with third level students and as such its recommendations are beyond the scope of this paper, its findings and the framework developed for communicating consent at third level may be of benefit in the context of junior and senior cycle RSE re-development.

6.12 Sex Education and Disability

The [Convention on the Rights of Persons with Disabilities](#) (CRPD), which has been ratified by Ireland, provides explicit rights to sexuality and sexual health services for people with disabilities in Articles 23 & 25.

While UNESCO technical guidance and systematic review upon which this good practice synthesis is based, emphasises the integration of disability into school-based sex education, no particular or specific guidance is provided. Pound *et al* do not appear to have considered disability as a core part of sex education at all. There are many barriers that preclude access by people with disabilities to school-based sex education not least lack of teacher preparedness or an absence of continued professional development in this regard.²⁴⁶ Notwithstanding, studies have demonstrated that sex education is beneficial for students with intellectual and physical disabilities.²⁴⁷ Sinclair *et al* illustrate a five step collaborative method for planning sex education programmes for people with disabilities that involves teachers, administrators, families and students with disabilities.²⁴⁸

A qualitative study examining the personal experiences and perceptions of adults with learning difficulties regarding their social-sexual lives reported that access to sexuality education was a priority for people with disabilities.²⁴⁹ Participants in this study received sexual information from school, parents/family and media sources with pornography cited by most participants as a primary source of information.²⁵⁰

²⁴³ MacNeela, P., Conway, T., Kavanagh, S., Kennedy, L.A., McCaffrey, J., Exploring How Attitudes to Alcohol Impact on Judgements about Consent to Sexual Activity: A Qualitative Study of University Students. Rape Crisis Network & National University of Ireland, Galway. 2014

²⁴⁴ MacNeela et al, Undated, 26

²⁴⁵ Ibid, 24

²⁴⁶ Howard-Barr, E. M., Rienzo, B. A., Pigg, R. M., & James, D. Teacher beliefs, professional preparation, and practices regarding exceptional students and sexuality education. *Journal of School Health*, 2005 75, 99–104; Sinclair, James, Laurie G. Kahn, Dawn A. Rowe, Valerie L. Mazzotti, Kara A. Hirano, and Christen Knowles. "Collaborating to Plan and Implement a Sex Education Curriculum for Individuals with Disabilities." *Career Development And Transition For Exceptional Individuals*, 2017, 40, no. 2: 123-128. ERIC, EBSCOhost (accessed August 24, 2018).

²⁴⁷ Dukes, E., & McGuire, B. E. (2009). Enhancing capacity to make sexually-related decisions in people with intellectual disability. *Journal of Intellectual Disability Research*, 53, 727–734.

²⁴⁸ Sinclair *et al*, 2017: 127

²⁴⁹ Turner, George W., and Betsy Crane. "Sexually Silenced No More, Adults with Learning Disabilities Speak Up: A Call to Action for Social Work to Frame Sexual Voice as a Social Justice Issue." *British Journal Of Social Work* 2016. 46, no. 8: 2300-2317. UK & Ireland Reference Centre, EBSCOhost (accessed August 24, 2018).

²⁵⁰ Turner *et al*, Sexually Silenced No More, 2016: 2307

Young people with disabilities have the same right to this education as their peers, however, some authors suggest that consideration must be made to modify programmes to enable age-appropriate information to be understood and learned in a way that is meaningful.²⁵¹ [Advocates for Youth](#), is a US-based organisation that advocates for policies and programmes that recognise young people's rights to health information. They provide and have developed sex education [guidance for young people with disabilities](#).

The [Irish Family Planning Association](#) (IFPA)²⁵² has emphasised that the absence of sex education can mean that people with disabilities may not have the language to communicate their sexual and reproductive needs or concerns.²⁵³ The IFPA provides access to a range of sex education materials for people with disabilities through its partner organisation in the UK.²⁵⁴

²⁵¹ Szydlowski, Mary Beth, and Youth Advocates for. "Sexual Health Education for Young People with Disabilities: Research and Resources for Parents/Guardians. From Research to Practice." Advocates for YouthERIC, 2016 EBSCOhost (accessed August 24, 2018).

²⁵² The Irish Family Planning Association is a not-for-profit sexual health provider. The organisation provides sexual and reproductive health, family planning, pregnancy counselling and education services.

²⁵³ Irish Family Planning Association, [Sexuality and Disability: Briefing Paper](#). Undated. [accessed 24th August 2018]

²⁵⁴ see <https://www.ifpa.ie/Education-Training/Disability-Sexuality-Resources>

7. Conclusion

Sex education is not an unambiguous, value-neutral concept, but one that is contested. The regulation of sexuality is fraught with difficulty in almost all jurisdictions with child sexuality particularly fractious. Even in countries where sex education is welcomed in principle, the content is often contentious.²⁵⁵ Ireland's relationship with sexual knowledge has, throughout the twentieth century in particular, reflected these wider tensions. Rising rates of crisis pregnancy, the threat posed by AIDS and the increasing liberalisation of Irish society have been catalysts for change giving way to a more liberal, morally relativist approach to sex education in recent decades. The United Nations and the World Health Organisation situate sex education in a rights-based framework that emphasises adolescent sexuality as an important stage in the human lifecycle. While this view is far from universally accepted, European democracies – more recently including Ireland – are generally more closely aligned with the international policy architecture for school-based sex education.

The systematic reviews consulted in the development of this *Spotlight* point to clear evidence that school-based sex education programmes can be effective in improving objective and reported sexual health outcomes.²⁵⁶ While school-based sex education is not enough by itself to prevent HIV or other STIs, UNESCO claims that it is a cost-effective strategy.²⁵⁷ Women who have experienced sex education in schools are also less likely to report having experienced rape, abortion or distress about sex.²⁵⁸ This is important in terms of Ireland's decision to repeal the 8th amendment to the Constitution in May 2018 as sex education is clearly a protective factor for crisis pregnancy and abortion.

However, sex education programmes alone will not offset other factors that have profound impacts on young people's sexual, reproductive and other health outcomes. Many factors combine to affect health and as such, sex education is unlikely to override - without other supports and services – the determinants of health in general.

The evidence-base for school-based sex education is fraught with challenges, not least in terms of contradictory findings. This *Spotlight* has selected two recent and scientifically robust systematic reviews of sex education from policy transferable settings as the basis upon which good practice is explored. These report that abstinence-only programmes are not effective in terms of promoting positive changes in sexual behaviour, while interventions that link school-based sex education with non-school-based youth-friendly health services optimise effectiveness. Young people want to learn about the risks but also the pleasures of sexuality within a 'sex-positive' framework and this is also reflected in Irish reviews of the RSE programme in post-primary schools. Comprehensive and holistic sex education provides impartial information on contraceptive options, safer sex, pregnancy and abortions, while more interactive methods of educational engagement are required for discussions around relationships and emotions. Notwithstanding, contraceptive and pregnancy options including abortion are found to be among the least discussed topics in sex education in international studies.²⁵⁹ Good practice would appear to suggest that sex education should be developed with input from young people.

Mayock *et al's* review of the RSE programme points to the paucity of emphasis on the needs of LGBTI students within the current curriculum but Ireland is not unique in this regard with a UK study highlighting that some young LGBTI students feel invisible in sex education classes. This finding is important in the context of epidemiological data for HIV in Ireland that mirrors a broader European trend in which young MSM are at particular risk. Furthermore, the *LGBTIreland* study

²⁵⁵ *Shaping Sexual Knowledge: A Cultural History of Sex Education in Twentieth Century Europe*. Ludz DH Sauerteig and Roger Davidson (Eds). Routledge: London and New York, 2009: 7

²⁵⁶ Pound *et al*, 2016, 9; UNESCO, 2016.

²⁵⁷ UNESCO, 2016: 4

²⁵⁸ Pound *et al*, 2016: 4

²⁵⁹ Pound, P., Langford, R., & Campbell, R., What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. *BMJ Open* 6(9) 2016: 10 doi:10.1136/bmjopen-2016-011329

found that almost half of all participants aged 14-25 years had taken drugs recreationally, which increases the likelihood of sexual risk taking and very early sexual initiation. Young *et al* also found that being bullied in school is associated with very early sexual initiation, which when combined with the findings of the *LGBTIreland* report suggests that LGBTI young people are at particular risk of poorer sexual health outcomes across the lifecycle.

The evidence appears to support the protective impact of sex education with a number of studies finding that young people who report lessons at school as their main source of information tend to be less likely to have had unsafe sex in the past year. Poorer choices and higher levels of risk-taking are generally associated with alcohol, tobacco and cannabis involvement and cannabis, in particular, has been found to be associated with very early sexual initiation for both boys and girls. These findings correspond with international research, which points to clear links between substance use and early sexual initiation. While the evidence is inconclusive, young Travellers and young boys from lower socio economic groups are also at increased risk of poorer sexual health outcomes. Girls from lower income families in Ireland are more likely to have been sexually active from a young age than those from higher socio-economic groups. As outlined previously, sex education programming will not override the determinants of health in general but it may provide an entry point to address the particular sexual health needs of vulnerable groups including young Travellers, young people with disabilities and young people from lower income families.

Since the RSE programme was developed in 1997, issues like consent, sexting, cyberbullying, online safety and sexual coercion have been foregrounded in national debate. The systematic reviews consulted in this *Spotlight* highlight the importance of including these issues on any contemporary curriculum. New technology has made pornography more easily accessible and there is growing evidence that viewing pornography is associated with violent or abusive behaviour in young men. One study found that boys who regularly viewed pornography online were more likely to admit to pressuring a partner into kissing, intimate touching, or intercourse. There is promising evidence pointing to the effectiveness of interventions that engage young men together with young women to reduce the levels of unprotected sex and these may provide an effective entry point for dialogue on consent, sexting and online pornography. A majority of young people (16-17 years) and all teaching staff (100%) in 39 schools in the London area felt that schools should be teaching about the risks associated with viewing online sexually explicit media. Reviews also emphasise the need to challenge rather than reinforce gender stereotypes and inequalities, while ensuring cultural sensitivity: this is perhaps where a whole-of-school approach may prove to be an efficient way of engaging parents and community services in RSE delivery and reinforcement.

Finally, the evidence points to the need for parental engagement in school-based sex education, with experts urging schools to become more proactively engaged with parents. Parents who struggle to communicate with their children about sex have said they welcome the guidance provided by the school curriculum. Parents also welcome the SPHE age-appropriate standardisation of learning, which helps to offset concerns about breaching the communication boundaries of other parents.

Appendix A: Methodology

This review of policy and practice for school-based sex education in Ireland was time-limited with parameters and scope of the study determined by the quality of secondary data sources. While the primary aim of the paper is to review the evidence base for school-based sex education – particularly evidence that is rooted in a liberal tradition as has been established in Ireland since the 1990s - there are many different types of reviews. Ideally, the most authoritative review (i.e. that which delivers the most robust and reliable scientific evidence) is a systematic review.²⁶⁰ Due to the resource and time limitations placed on the production of this *Spotlight* it was not possible to undertake a systematic review of the evidence base for school-based sex education. As such, the good practice chapter is largely informed by two policy-transferable systematic reviews recently undertaken by reputable sources, as follows:

1. Pound P, Denford S, Shucksmith J, et al. *What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views*. BMJ Open 2017;7:e014791. doi: 10.1136/bmjopen-2016-014791; and
2. UNESCO. *Review of the Evidence on Sexuality Education. Report to inform the update of the UNESCO International Technical Guidance on Sexuality Education*; prepared by Paul Montgomery and Wendy Knerr, University of Oxford Centre for Evidence-Based Intervention. Paris, UNESCO. (2016).

The selection of these studies should not be seen to supplant or undermine the validity of other studies with similar or contrary findings that may not have come to the author's attention. The findings of these two reviews are sometimes complemented with additional relevant and topical research that is Irish-specific or published in the Journal of Sex Education in 2017 and 2018. The author has further identified five thematic areas not sufficiently explored by the systematic reviews upon which the good practice chapter is based. These are:

1. the needs of LGBTI;
2. people with disabilities;
3. consent;
4. online pornography;
5. the role of parents in supporting the delivery of school-based sex education.

This review should not be read as an evaluation or audit, and no attempt has been made to compare the performance of school-based sex education programmes in different jurisdictions against each other, not least because the detailed contents of different programmes are not comprehensively described in the literature. The enduring 'problem' of sex education in every jurisdiction is that it is underpinned by diametrically opposed philosophical positions. While this *Spotlight* considered Ireland's transition from a minimalist and morally absolutist approach to school-based sex education, the time limitations of this review of the evidence precluded interrogation of multiple perspectives. Consequently, the evidence assessment which informs the chapter on good practice for school-based sex education incorporates evidence which favours a liberal and comprehensive approach as adopted by Ireland since the mid-1990s and the majority of EU member states.

²⁶⁰ The primary aim of a systematic review is to identify all relevant studies on a specific topic as comprehensively as possible, and to select appropriate studies based on explicit and pre-determined criteria. These studies are then assessed to ascertain their internal validity. Centre for Evidence-based Management [accessed 4th September 2018]

Appendix B: Definitions

Sex, sexuality, sexual health and rights are neither fixed nor value neutral concepts and are therefore interpreted differently in different countries. This paper relies on definitions put forward by the World Health Organisation, which in 2002 convened an international technical consultation in Geneva to define these concepts:

- **“Sex”** refers to biological characteristics that define humans generally as female or male although in the vernacular it can also refer to sexual activity;
- **“Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, ethical, legal, historical, religious and spiritual factors.”**²⁶¹ This definition emphasises that relationship and sexuality education is wider and more diverse than a focus on sexual behaviour and sexual outcomes including disease and/or crisis pregnancy;
- **“Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”**²⁶² This is the definition of sexual health that has been adopted by Ireland’s National Sexual Health Strategy.²⁶³
- **“Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements.** They include the right of all persons, free of coercion, discrimination and violence, to:

the highest attainable standard of sexual health, including access to sexual and reproductive health care services;

 - seek, receive and impart information related to sexuality;
 - sexuality education;
 - respect for bodily integrity;
 - choose their partner;
 - decide to be sexually active or not;
 - consensual sexual relations;
 - consensual marriage;
 - decide whether or not, and when, to have children; and
 - pursue a satisfying, safe and pleasurable sexual life.

²⁶¹ WHO (2006) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva, available at http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

²⁶² Ibid

²⁶³ Department of Health, [National Sexual Health Strategy 2015-2020](#). (Dublin: 2015, p. 8)

The responsible exercise of human rights requires that all persons respect the rights of others.”²⁶⁴

LGBTI is the acronym for Lesbian, Gay, Bisexual, Transgender and Intersex used throughout this paper. The following definitions are provided by the [LGBTIreland Report: national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland \(2018\)](#):

- **Bisexual** is a term used to describe someone who is sexually, emotionally and romantically attracted to both men and women.
- **Cisgender** is a term used to describe an individual's gender when their experiences of their gender correspond to the biological sex they were assigned at birth.
- **Coming out** is a process that involves a lesbian, gay, bisexual, transgender or intersex person developing an awareness of an LGBTI identity, accepting their sexual orientation or gender identity, choosing to share the information with others and building a positive LGBTI identity. It not only involves coming out, but staying out and dealing with the potential challenges that one might encounter as an LGBTI person.
- **Gay** is a term traditionally used to describe a man who is sexually, emotionally and romantically attracted to other men. While the term 'lesbian' is typically used to describe women who are attracted to other women, many women with same-sex attractions self-identify as 'gay'.
- **Gender identity** refers to a person's deeply-felt identification as male, female, or some other gender. This may or may not correspond to the sex they were assigned at birth.
- **Heteronormative**, or the 'heterosexual norm', refers to the assumption that heterosexuality is the only sexual orientation. It is closely related to 'heterosexism' (see below) and can often cause other sexual orientations to be ignored and excluded.
- **Heterosexual** is a term used to describe someone who is sexually, emotionally and romantically attracted to a person of the opposite sex.
- **Heterosexism** is the assumption that being heterosexual is the typical and 'normal' sexual orientation, with an underlying assumption that it is the superior sexual orientation. This assumption often results in an insensitivity, exclusion or discrimination towards other sexual orientations and gender identities, including LGBT.
- **Homophobia** is prejudicial or discriminatory attitudes and/or behaviour directed at gay men or lesbian women, whether intended or unintended.
- **Intersex** stands for the spectrum of variations of sex characteristics that occur within the human species. It is a term used to describe individuals who are born with sex characteristics (chromosomes, genitals, and/or hormonal structure) that do not belong strictly to male or female categories, or that belong to both at the same time. 'Intersex' also

²⁶⁴ WHO (2006) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva, available at http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

stands for the acceptance of the physical fact that sex is a spectrum and that people with variations of sex characteristics other than male or female do exist.

- **Lesbian** is a term used to describe a woman who is sexually, emotionally and romantically attracted to other women.
- **Sexual orientation** refers to an enduring pattern of emotional, romantic or sexual attraction to men, women or both. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual. People who do not experience attraction to any sex may define themselves as asexual.
- **Transgender** is an umbrella term referring to people whose gender identity and/or gender expression differs from conventional expectations based on the gender they were assigned at birth. This can include people who self-identify as transsexual, transvestite, cross-dressers, drag performers, genderqueer, and gender variant. Transgender is commonly abbreviated to trans.



Contact:

Houses of the Oireachtas
Leinster House
Kildare Street
Dublin 2
D02 XR20

www.oireachtas.ie

Tel: +353 (0)1 6183000 or 076 1001700

Twitter: @OireachtasNews

Library & Research Service

<http://library>

Tel: +353 (0)1 6184701

Email: library.and.research@oireachtas.ie

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