SEX EDUCATION FORUM
working together for quality sex and relationships education

SRE - the evidence

This briefing aims to provide an accessible and accurate summary of the research evidence relating to sex and relationships education (SRE), particularly the contribution of SRE to behaviour change. It includes findings about SRE from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal).

What is sex and relationships education?

Sex and relationships education (SRE) is learning about the emotional, social and physical aspects of growing up; relationships; sex; human sexuality; and sexual health.

What does sex and relationships education aim to achieve?

SRE aims to equip children and young people with the information, skills and values they need to have safe, fulfilling and enjoyable relationships and to take responsibility for their sexual health and well-being.

SRE aims to contribute to behaviour change, including reducing unprotected and unwanted sex, and reducing harmful behaviour, including sexual offences such as assault and abuse. Good quality SRE also fulfills children and young people's right to information about their bodies and health.

Does sex and relationships education work?

Young people start having sex at an older age

National and international research shows that good quality SRE has a protective function as young people who have had good SRE are more likely to choose to have sex for the first time later. There is no evidence that SRE hastens the first experience of sex. These findings are confirmed by three separate evidence reviews: Kirby 2007, UNESCO 2009 and NICE 2010. Kirby (2007) examined 48 US-based comprehensive SRE programmes, i.e. which included information about contraception and also the benefits of delaying first sex, and found that two-thirds of these programmes had positive effects on behaviour. 40 per cent* of the programmes had a significant impact in three aspects of behaviour: delaying the initiation of sex; reducing the number of sexual partners; and increasing condom or contraceptive use. None of the studies hastened the first experience of sex. Some SRE programmes have been found to reduce the frequency of sex – none of the programmes reviewed by Kirby (2007) resulted in young people having sex more frequently later than others.

The message that young people should wait until they are ready to have sex forms the basis of all good quality, comprehensive SRE programmes. There is good evidence that a 'just say no' or 'abstinence only' approach combined with no information (or incorrect information) about contraception is not effective in changing behaviour in the long term (Guttmacher Institute 2007). Teaching young people about contraception does not contradict messages about delaying the first experience of sex (Kirby 2008).

First sex more likely to be wanted, protected and competent

Research shows that young people who have taken part in a good quality SRE programme are more likely to use condoms and contraception when they first have sex (Kirby 2007). So a broad, comprehensive programme of SRE that includes learning about contraception is essential.

* Not all of the 48 programmes measured impact on all aspects of behaviour. See Kirby (2007) for further information.

The British National Surveys of Sexual Attitudes and Lifestyles (Natsal) found that men and women who reported school lessons as their main source of sex education (vs. friends/other sources) were more likely to be 'sexually competent' at first sex, i.e. not only were they less likely to report first intercourse before age 16 but also more likely to report that at that time: a reliable method of contraception was used; and that the timing felt right; and that their decision to have sex was an autonomous one and that both partners were equally willing (Wellings, 1995; Wellings, 2001; Macdowall 2015).

Unwanted first sex and partnerships with a big age difference are associated with poorer sexual and reproductive health outcomes, including sexually transmitted infections (STIs), pregnancy, and less contraceptive use. Partnerships with a big age difference (age-discrepancy) are also associated with intimate partner violence (Barter, 2009).

In a large study carried out in the United States, female respondents who had received 'comprehensive sexuality education' were less likely to have a partner with a big age difference (3 years or more younger/older) at first sex and more likely to describe first sex as wanted, compared to those receiving abstinence only or no SRE. Male respondents were less likely to have had an age-discrepant partner at first sex if they had had either type of SRE. In this United States study Lindberg also found that young people who had received comprehensive SRE were less likely to describe first sex as unwanted (Lindberg, 2012).

The Lindberg research demonstrates that the protective influence of SRE is not limited to the questions of if or when to have sex, but extends to issues of partner selection.

Longer term benefits to health and well-being associated with SRE

Natsal participants were asked about their main source of information about sex when growing up. The findings from Natsal-3 (the most recent survey) show that those whose main source of information was lessons at school were less likely to have an unplanned pregnancy later in life (Wellings, 2013).

Receiving comprehensive SRE was associated with being less likely to have had six or more sexual partners, and (for males) to be more likely to have used a condom at most recent sex and less likely to have been treated for an STI (Lindberg, 2012). The influence of SRE on these longer term outcomes such as number of partners is likely to work through delaying first sex, as age at first sex has stronger associations with longer term outcomes than SRE does.

The research on longer term outcomes points to the importance of SRE beginning before first sex because there are a range of longer-term benefits associated with delaying first sex.

Further detail about the Natsal-3 SRE findings are provided in the special insert and infographics.

Policy and practice in England

There has never been a consistently applied policy on SRE in England that has ensured all children and young people get a basic level of education about sex, relationships, the law and safety from sexual abuse. Currently the quality and extent of SRE provision in English schools varies greatly, with Ofsted reporting that over a third of primary schools and almost half of secondary schools require improvement in SRE (2013). Many teachers have no training in SRE, with 7 in 10 saying that they need more training to deliver the subject properly (Sex Education Forum, 2014).

However, case-study research carried out in England has found that areas of the country which had achieved the greatest reductions in teenage conception rates had provided both good quality school SRE as well as accessible sexual health services for young people (DfES 2006).

The lack of education about reproduction and preparation for adult life has been identified by the UN

Committee on the Rights of the Child (UNCRC) as a children's rights issue that needs urgent attention in the UK (UNCRC 2008). The UN Special Rapporteur on violence against women at the end of her visit to the UK, asserted that "in order to play a truly transformative role in the longer term, this [This is Abuse] campaign, as well as similar initiatives, need to be part of the curriculum and be institutionalized in the education system" (UN 2014, p2). Legally, the age of criminal responsibility in England is 10 years old, which makes children aged 10 and above responsible for their sexual conduct, but without necessarily having received any education or advice about the laws relating to sex, consent and coercion. The legal age of consent is 16.

International support

The UNESCO international guidance on 'sexuality education'[1] (2009) sets out the evidence supporting sexuality education and details what should be included in the curriculum for children and young people between the ages of 5 and 18. The guidance urges both developing and developed countries to make sure all children and young people learn about HIV, contraception, human sexuality and relationships.

Case study: the USA and California

The USA has now cut funding for abstinence-only education programmes at home and abroad. Policy varies between states but the teenage pregnancy rate in California reduced by 52 per cent (from 1992–2005), which was far above the national decline of 37 per cent. California is the only state that never accepted federal funding for abstinence-only programmes. In 2003 a law was introduced requiring that any school based sex education programmes be medically accurate, age-appropriate and comprehensive. Access to free contraception was also increased during this period (Boonstra 2010 and see also Boonstra 2014).

Case study: Finland

The evidence from Finland shows that applying a clear policy on SRE at the national level can impact directly on teenage sexual behaviour. 'Sexuality education' was made compulsory in schools in 1970, but was downgraded to an optional subject in 1994. At this point, the quality and quantity of provision declined, and resources for sexual health services were also cut. Finland experienced a 50 per cent increase in teenage abortions in the late 1990s as well as an increase in girls starting to have sex at the age of 14 and 15 and a fall in use of contraception. A decade later a new subject called 'Health' was introduced in schools and has been compulsory in primary and secondary schools from 2006. Some year groups must have a minimum of 20 hours teaching in the subject and teachers are now given training. The trend in teenage sexual behaviour has now reversed; girls are starting to have sex at an older age and more are using contraception. The rate of teenage abortions has also dropped and there has been a small decline in teenage births. (Apter 2009).

[1] The term 'sexuality education' is widely used in international literature. 'Sex education' and the broader 'sex and relationships education' are more commonly used in England. Definitions vary, but refer to the definition of sex and relationships education presented on page 1 of this briefing for the Sex Education Forum definition.

Case study: Estonia

During the Soviet period there was no formal SRE in Estonia. A school lesson on 'personal hygiene' was introduced in 1963 and this was a precursor to another single lesson provided to all pupils aged 15-16 from 1980 on the topic of 'family studies'. After independence, a general education curriculum that included elements of SRE as part of a compulsory subject 'human and civil studies' was developed and implemented by 1996. Further changes were made to the curriculum in 2000-2001, partly driven by the HIV epidemic in the country, and the subject evolved to become 'human studies'. Teachers have the option to decide how many lessons to dedicate to SRE within human studies, but the topic selection in the curriculum is wide with a core set of compulsory topics. An estimated 18% of human studies lessons are dedicated to SRE. Pupils also learn about the reproductive organs in biology.

The level of specialist training that teachers undergo varies. In 2003 surveys showed that while some human studies teachers had undertaken post-graduate training in SRE others had received no specialist training. SRE lectures from local health professionals are often combined with the teacher-led input.

The development of the SRE programme and youth-friendly health services in Estonia has been a gradual process, starting after the country became independent in the early 1990s, and would only have an impact on sexual health indicators after a few years, as pupils receive SRE before they are sexually active. Studies show that SRE was quite well established and integrated in the majority of schools by 2004-5. Youth sexual health indicators in Estonia have shown dramatic improvements over the past two decades. The abortion and fertility rates among 15– to 19-year-olds declined by 61 per cent and 59 per cent respectively between 1992 and 2009. Further, the annual number of registered new HIV cases among 15- to 19-year-olds declined from 560 in 2001 to just 25 in 2009.

UNESCO has analysed the costs and cost-effectiveness of the introduction of SRE within human studies in Estonia, and concludes that the intervention in Estonia is an excellent example of a fully scaled up, integrated, intra-curricular programme at relatively low cost, with important lessons for other countries. (UNESCO 2011).

Case study Latin America and the Caribbean

Health and education ministers from Latin America and the Caribbean signed a historic declaration in 2008 giving their support to national school based sexuality and HIV education throughout the region and endorsed the scientific evidence that backs this approach (UNAIDS 2008). This includes a target to have reduced the number of schools (administered by the Ministries of Education) that do not provide comprehensive sexuality education by 75% by the year 2015.

Is sex and relationships education enough?

Good quality SRE is vital but, on its own, is not enough. Young people also need to be able to access sexual health and contraceptive services in places that are convenient to them (Santelli, 2007), and to be supported in their emotional development. Good SRE, together with access to sexual health services, can contribute to the following public health priorities:

- earlier reporting of sexual abuse and, in some cases, its prevention
- reduced number of unplanned pregnancies
- reduced number of teenage pregnancies
- prevention and earlier treatment of sexually transmitted infections
- reduced gap in health inequality

Wider factors such as poverty and education are also important. There is a strong link between teenage conception and educational attainment (DfES 2006). The influence of societal factors including child-bearing norms and poverty are explored by Boonstra in the context of declining teenage pregnancy rates in the United States (2014). Boonstra acknowledges the complex relationships of several societal factors and recommends the expansion of access to both information and services for young people.

Is it cost effective?

UNESCO has analysed the costs and cost-effectiveness of SRE programmes in six countries (2011) (including the Estonia case-study summarized on the previous page) and found programmes are potentially cost-effective and cost-saving but depend on certain contextual factors. To maximize effectiveness good quality SRE programmes should be scaled-up to national coverage with full uptake in schools and should be delivered within the curriculum and in conjunction with health services. UNESCO has published a guide to the opportunities and challenges of scaling up 'comprehensive sexuality education' (2014).

There are also cost benefits to providing contraceptive services. 'It has been estimated that every £1 spent on contraception services saves the NHS £11 (McGuire 1995).

What is good quality sex and relationships education?

Researchers (Kirby 2007 and 2008, and Trivedi 2007) have identified characteristics of effective SRE programmes including:

- a comprehensive range of topics is addressed, including contraception
- trained educators are used
- programmes begin before a young person first has sex
- 'psychosocial' factors, which affect behaviour, including values, norms and self-efficacy, are addressed
- participatory learning methods are used
- children and young people are taught using small group work.
- both school and home contribute to SRE

How can good quality sex and relationships education be provided?

Through our extensive experience, contact with professionals and informed by the evidence base, the Sex Education Forum recommends the approach described below is used to deliver good quality SRE. The key features listed provide a summary only; see also the Sex Education Forum values and principles for SRE at www.sexeducationforum.org.uk/about-us/values-principles.aspx

1. Comprehensive SRE for all children and young people

All children and young people must receive SRE, regardless of their gender, sexual orientation, disability, ethnicity, culture, age, religion or belief or other life experiences, particularly HIV status and pregnancy. Ensuring that SRE has a timetabled slot in school as part of dedicated personal, social, health and economic (PSHE) education lessons, helps guarantee that no child or young person will miss out on vital information.

SRE should respond to the current needs of children and address 21st century concerns such as the distorted messages conveyed by pornography which are now so accessible via internet technology.

2. Trained educators

SRE needs to be taught by willing and competent teachers. Young people have said SRE is best when teachers are confident, unembarrassed and able to teach correct biological facts and also explore relationships issues. In a Sex Education Forum survey (2008) very few teachers (3 per cent) reported that SRE

was covered adequately within their initial teacher training and 7 in 10 say that they need more training to teach the subject properly (2014).

3. An age-appropriate programme

Evidence shows that SRE works best if it starts before a young person has their first experience of sex and if it responds to the needs of young people as they mature. SRE must start in primary school and be taught in an age-appropriate manner, starting with topics such as personal safety, bodily boundaries and friendships. Both primary and secondary school pupils, particularly girls, have said they need SRE to start earlier (Ofsted 2010 and 2013).

The Sex Education Forum curriculum design tool shows what an age-appropriate SRE programme covers at each age and stage: www.sexeducationforum.org.uk/resources

4. Medically and factually correct information

SRE can have an important role in busting unhelpful myths so it must be based on medically correct information about contraception, reproduction and sexual health. Correct names for sexual parts of the body should be taught including to younger children – this provides the language to describe unwanted behaviour and report abuse (Ofsted 2013). A range of views on sex and relationships can be discussed, including faith perspectives, but teachers must be clear when they are presenting facts and when they are presenting opinions or beliefs.

5. Promoting core values

Clear core values run through good quality SRE, including consent, mutual respect, enjoyable relationships, rights to information, safety and health, equality (particularly on the basis of gender and sexual orientation) and responsibility for oneself and others. Good quality SRE can provide a safe space for children and young people to identify and reflect on their own values and those of others, including their peers and influences from the media. For practical examples of SRE in faith contexts, see www.sexeducationforum.org.uk/practice

6. Developing skills

Evidence shows that SRE is more effective if it develops children and young people's skills as well as knowledge. Participatory and interactive learning tasks need to be built into SRE so that skills such as communication, reaching agreement and listening can be practiced and developed. When SRE is integrated within PSHE education there are opportunities for development of a range of inter-personal skills.

7. Partnership with parents and carers

Children and young people are clear that they want to talk to their parents and carers about sex and relationships. Many parents and carers feel they lack the skills, confidence and knowledge to talk to their children, and look to schools for support. Schools and parents need to work together to make sure children and young people get the information and support they need.

Who wants good quality SRE in England?

Making sure that all children and young people receive good quality SRE will take time and effort. Currently 75 per cent of young people rate their SRE as very bad, bad or OK, and only 25 per cent rate it good or very good (Sex Education Forum 2013). Ofsted have repeatedly expressed concern about the patchiness of SRE provision and its poor quality, particularly where teachers have not received training and SRE is not given space in the timetable (Ofsted 2007, 2010 and 2013 and see also IPPF 2014).

But there is also a strong foundation of support to build on, with high levels of public and professional support for SRE. For example, 88 per cent of parents of school-aged children believe that sex education and lessons on adult and peer relationships should be mandatory in schools (NAHT 2013).

The Sex Education Forum is campaigning for statutory SRE as part of an entitlement to PSHE education in schools.

Sex Education Forum

The Sex Education Forum is a unique collaboration of individuals and organizations which was founded in 1987. Our members believe that all children and young people are entitled to good quality SRE. We work with our members and partners to support the provision of good quality SRE. Members of the Sex Education Forum receive regular updates about new research and policy and receive a termly e-magazine which looks in depth at practice issues.

For more information visit www.sexeducationforum.org.uk/membership

For more information about evidence and research visit www.sexeducationforum.org.uk/evidence

Learning about sex: key messages and infographics

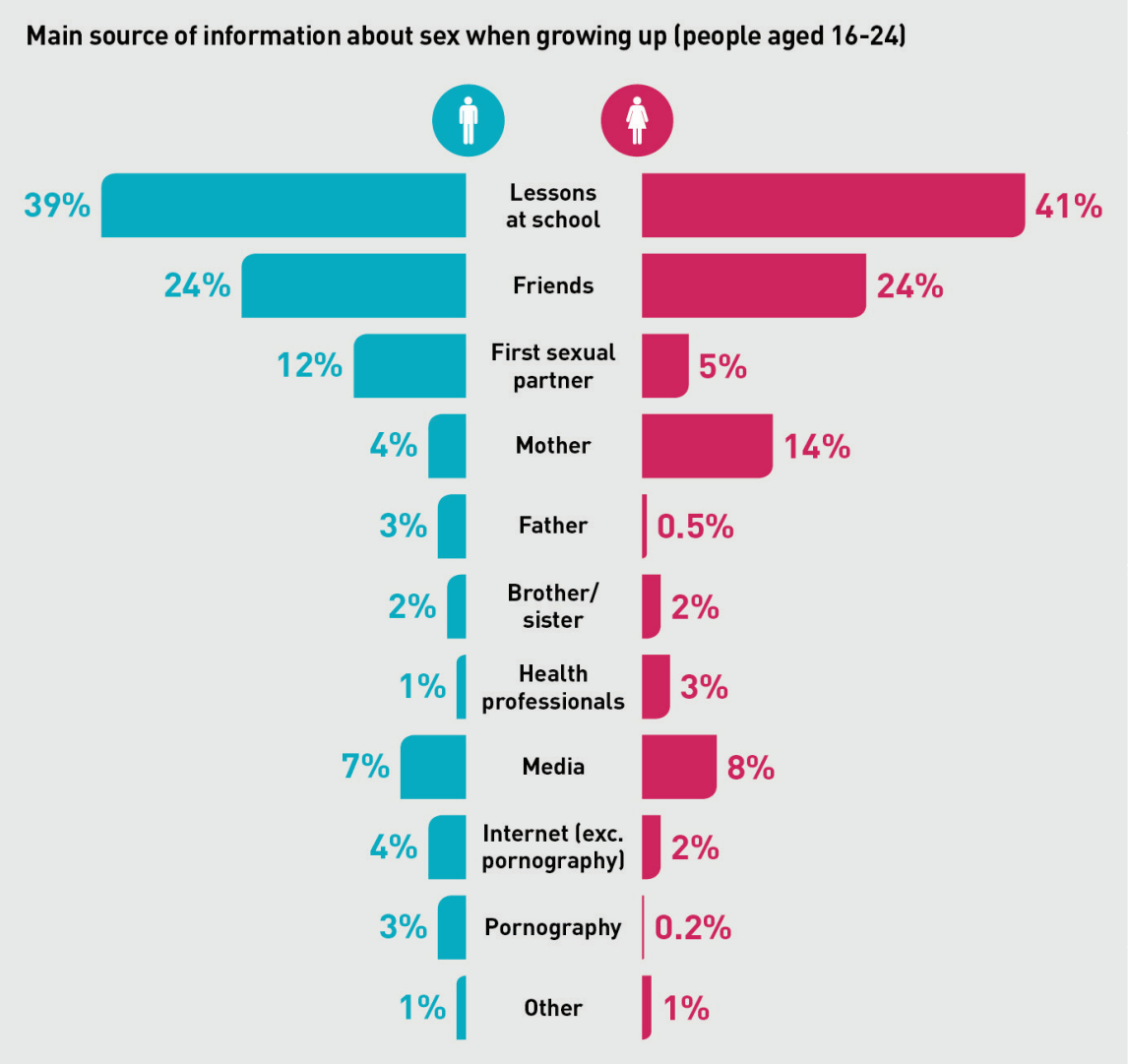
Findings from Natsal-3: learning about sex in Britain

The third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3) carried out in 2010-2012 gathered information about sexual experiences, behaviours, and views from nearly 4,000 young people (16-24 years). Those who took part were asked how they learned about sex when they were growing up, what their main source of information was, whether they knew enough when they first felt ready for some sexual experience and, for those who thought they ought to have known more, who they would have liked to provide that information. It is possible to track change over time by comparing the responses of 16-24 year olds in the first, second and third surveys (Natsal-1 in 1990-1991, Natsal-2 in 1999-2001 and Natsal-3 in 2010-12).

These notes accompany the infographics overleaf and outline the findings from the most recent Natsal survey about learning about sex, published in the BMJ Open (Tanton 2015 and Macdowall 2015).

Main source of information about sex when growing up (people aged 16-24) and preferred source

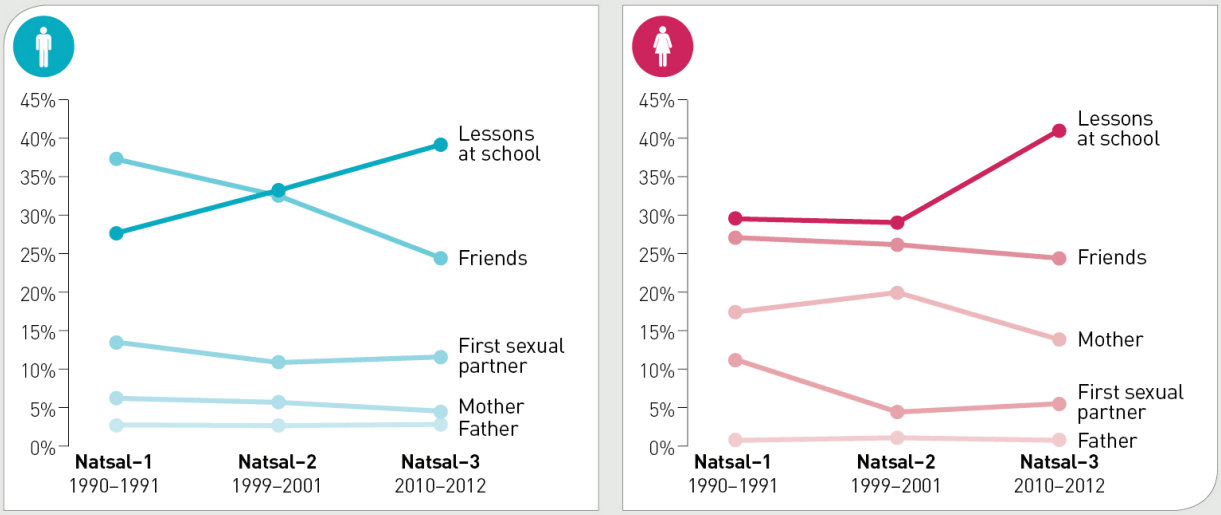
Around 40% of young people now say that lessons at school are their main source of information about sex and this proportion has increased over the past two decades, while the proportion of men saying friends (of about the same age) were their main source, and women saying their mother or their first boyfriend/sexual partner was their main source has decreased.



Most young people (around 70%) said that they didn't know enough when they first felt ready to have some sexual experience. There has been no substantial change in this proportion over the past two decades.

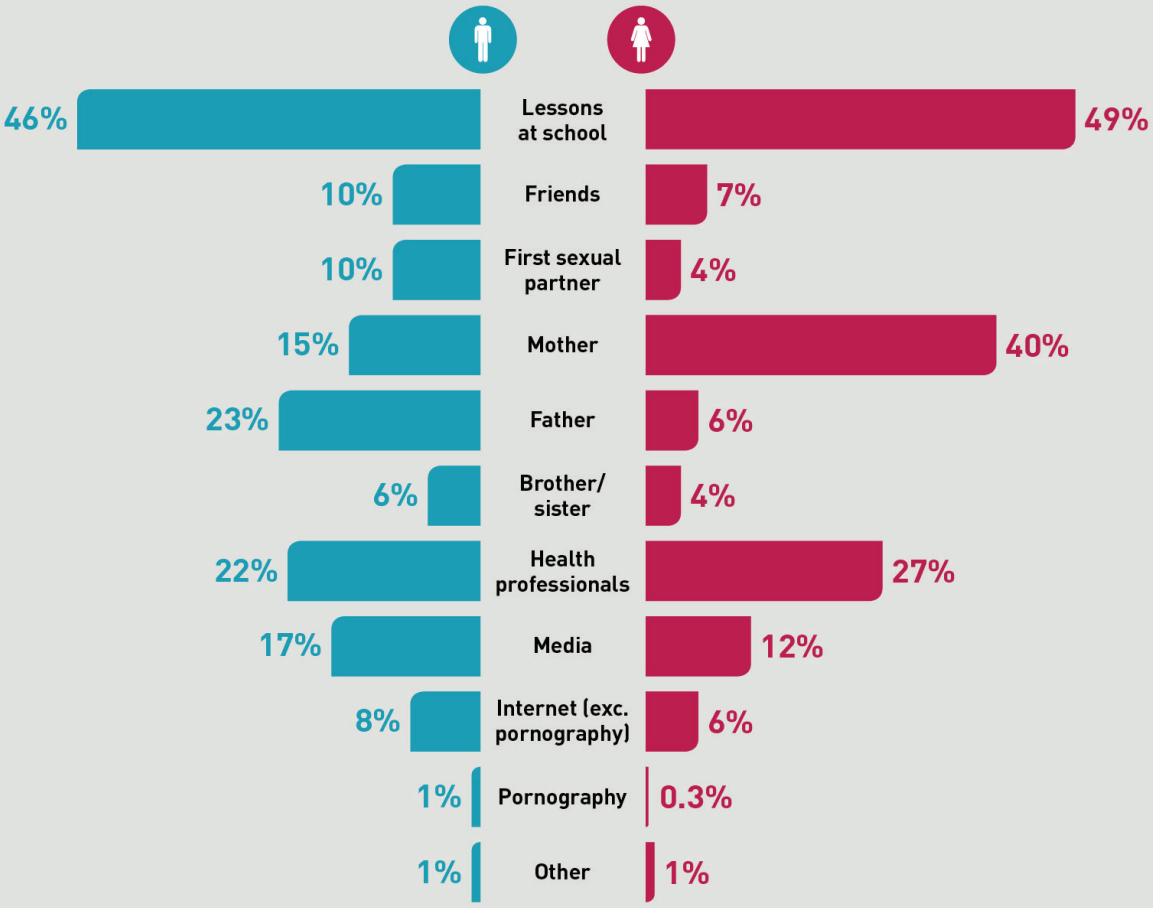
These young people said they would like to have learned more about sex from lessons at school, parents, or health professionals.

Change over time in main source of information about sex (people aged 16-24)



Preferred source of information about sex when growing up (people aged 16-24)

70% of young people said they didn't know enough when they first felt ready to have some sexual experience. They would have liked to get more information from the following sources:



Participants could give one or two answers so the percentages sum to more than 100%.

Associations between main source of information about sex and sexual health outcomes

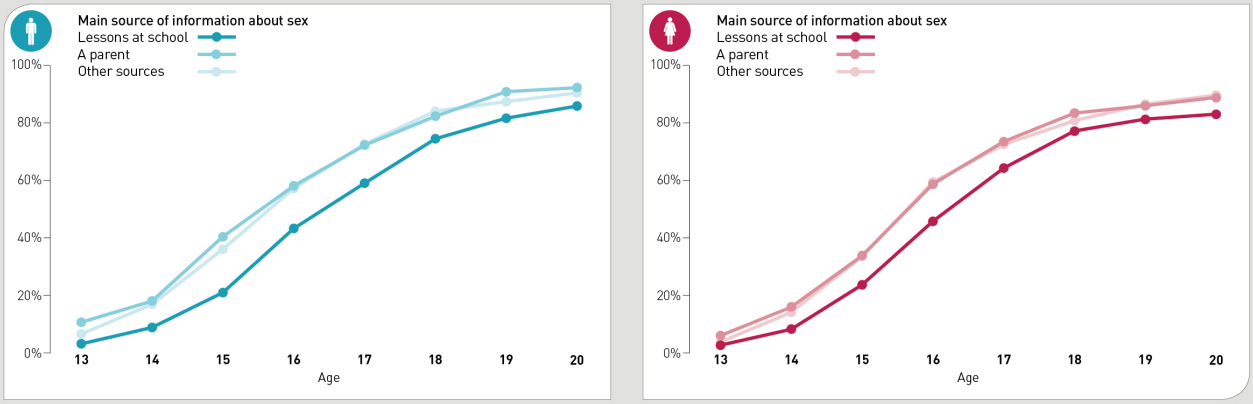
The Natsal surveys are representative 'snapshots' of the population, which allow us to look at associations between how people learn about sex and later sexual health outcomes, although they can't tell us about causation.

After grouping main source of information into three categories: 'lessons at school', 'a parent', and 'other sources', and after taking account of the effect of age and educational level, young people's responses showed that those who mainly learned about sex from school lessons were less likely to have had sexual intercourse before age 16, unsafe sex in the past year (defined as one or more new partner without using a condom), and to have ever been diagnosed with a sexually transmitted infection (STI), compared with those who mainly learned from other sources.

Women for whom school was their main source were also more likely to have been sexually competent* at first sex, and less likely to have had an abortion or experienced sex against their will, or to have felt distressed about their sex life in the past year. However, there was no association with these outcomes for men.

Although few people (less than 8% of men and less than 14% of women) said a parent had been their main source of information, those who did were less likely to have had unsafe sex in the past year. Women (but not men) with a parent as the main source were also less likely to have been diagnosed with an STI.

Percentage who have had sexual intercourse with someone of the opposite sex at or before each age, by main source of information about sex



Men and women who said that lessons at school were their main source of information about sex were more likely to have started having sex at a later age than those for whom parents or other sources were their main source, even after taking account of age and educational level. For example, around 20% of men with lessons at school as their main source have had sex at/before age 15 (before their 16th birthday), compared with around 36% of men with other main sources.

* 'sexually competent' at first sex means that not only were they less likely to report first intercourse before age 16 but also more likely to report that at that time: a reliable method of contraception was used; and that the timing felt right; and that their decision to have sex was an autonomous one and that both partners were equally willing.

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