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SEXUALITY, INFORMATION
REPRODUCTIVE HEALTH & RIGHTS

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The Irish Family Planning Association welcomes the review by the Joint Committee on Education and Skills of sexual health and relationship education.

1. About the Irish Family Planning Association

1.1 The Irish Family Planning Association (IFPA) submits these remarks on the basis of our many years of experience as a provider of sexual health services. Since 1969, the IFPA has worked to promote and protect basic human rights in relation to reproductive and sexual health, relationships and sexuality. The IFPA provides the highest quality reproductive health care at its two medical clinics in Dublin and ten counselling centres across Ireland. Our services include non-directive pregnancy counselling, family planning and contraceptive services, medical training for doctors and nurses, free post-abortion medical check-ups and educational services. In 2015, the IFPA medical clinics provided over 12,000 sexual and reproductive health services and provided information and support to 3,400 women and girls experiencing pregnancies that were unintended or that had developed into a crisis because of changed circumstances.

1.2 The IFPA has many years of experience of developing and delivering sexuality education and training to young people, parents, teachers, youth workers and carers, and was at the vanguard of sexuality education prior to the development of the Relationships and Sexuality Education (RSE) curriculum for schools. The IFPA currently provides a range of programmes, including a five-hour sexual health session which can be delivered as part of the RSE curriculum in Irish secondary schools. The IFPA also runs a programme called 'Speakeasy' which is designed to provide parents, guardians or carers with the information, skills and confidence needed to talk to their children openly about relationships, sexuality and keeping safe. Our 'Speakeasy Plus' programme focuses specifically on parents, carers and other service providers working with children who have disabilities or extra support needs. The IFPA has published a manual on Sexuality and Disability and worked extensively in the design and delivery of sexuality education programmes for young people with intellectual disability.

2. The need for comprehensive sexuality education

2.1 Sexuality education plays a critical role in the preparation of young people for a safe, productive, fulfilling life by providing them with the means to protect themselves from the risks of sexually transmitted infections, unintended pregnancies, gender-based violence and gender inequality. High quality comprehensive sexuality education facilitates the development of accurate and age appropriate knowledge, attitudes and skills. It promotes positive values, including respect for human rights, gender equality and diversity. It fosters attitudes and skills that contribute to safe, healthy, positive relationships and provides an important opportunity to reach young people with accurate information before they become sexually active, as well as offering a structured environment of learning within which to do so.

2.2 The Citizens' Assembly and the Joint Oireachtas Committee on the Eighth Amendment processes have created an unprecedented momentum in relation to sexual and reproductive health and unintended pregnancy. Critically both bodies took a holistic approach to unintended pregnancy and recognised that repeal of the Eighth Amendment to allow for the provision of safe and regulated abortion services must be accompanied by measures to tackle unintended pregnancy. Provision of free contraceptive services to ensure that women and girls have access to the full range of the most effective modern methods is critical to reducing the level of unintended pregnancy. Comprehensive sexuality education is the indispensable primary healthcare measure to ensure that people in Ireland are equipped from a young age and throughout their lives to make informed decisions about their sexuality and relationships; are protected from sexually transmitted infection; and are empowered to avoid unintended pregnancy.

2.3 Furthermore, in a context where young people have greater exposure to sexually explicit material via the internet and social media, there has never been a greater need for high-quality, comprehensive sexuality education. This could not have been foreseen when the Education Act 1998 was enacted and allowed schools that have a religious ethos to prevent aspects of relationships and sexuality being discussed. But in the context of young people's lives in today's world, preventing comprehensive discussion of sexuality and relationships is harmful and exposes young people to risk. In its concluding observations to Ireland following its 2016 review of implementation of the United Nations (UN) Convention on the Rights of the Child, the UN Committee on the Rights of the Child called on the state to develop a comprehensive sexual and reproductive health policy for adolescents. .[1]

2.4 Young people face increasing pressures regarding sex and sexuality including conflicting messages and norms. On the one hand sex is seen as negative and associated with guilt, fear and disease, but through the media and friends it is portrayed as positive and desirable. Such pressures may be perpetuated by a lack of accurate information, skills, and awareness of their rights and by gender expectations. Young people may feel that they lack a voice in a debate which is about them, but rarely involves them, or that the reality of their lives and the development of their sexual identities are not understood. This results in many young people being either unable or reluctant to seek help when they need it, and may prevent them from giving input within policy and decision making processes.[2]

2.5 The IFPA is committed to the provision and promotion of youth friendly services which are easily available to all young people irrespective of their age, sex, marital status or financial situation. We recognise the right of all young people to enjoy sex and express their sexuality in the way that they choose. We are committed to promoting, protecting and upholding the sexual and reproductive health rights of all young people. This includes the right to information and education on sexuality, and a right to pleasure and confidence in relationships and all aspects of their sexuality. Such information and education should enhance the independence

and selfesteem of young people and provide them with the knowledge and confidence to make informed choices. As Ireland's leading sexual health charity, the IFPA is deeply concerned at the public health impact of inadequate, inconsistent and poor quality sexuality education in many schools in Ireland.

2.6 In the IFPA's view, this represents a failure to provide young people with the means to protect themselves from unintended pregnancy and sexually transmitted infection, and is a derogation of schools' and, by extension, the state's safeguarding role.

2.7 We know from our training and education services that, while parents and teachers tend to be supportive of sexuality education, school ethos creates significant barriers to the delivery of an adequate level of information. Parents are frequently unaware that Boards of Management define school policy on this issue and that schools are not obliged to cover all aspects of sexual and reproductive health. For example, the IFPA has many times been obliged to turn down requests from schools to deliver sessions, because we are asked to omit references to contraception. We frequently encounter young people in our services who have not received basic education on matters of sexual health. We have concerns about inadequate attention to gender equality: the responsibility for avoiding pregnancy falls almost entirely on young women. And the specific RSE needs of LGBTQI youth are rarely addressed in any adequate manner in schools.

2.8 Failure to provide safe spaces where children, especially young teenagers, can raise questions, discuss concerns and clarify information about sexuality and sexual health exposes them to serious risk: we know from our training and education programmes that young people tend to uncritically accept social media imagery, language and portrayals of sexual behaviour as fact. Their expectations, attitudes and language can be unwittingly shaped by pornography, fantasy and misinformation and they may be unable to distinguish between healthy relationships and abusive or exploitative relationships. We also know that parents and teachers tend be unaware of just how much sexually explicit material young people are exposed to on social media.

2.9 The IFPA works extensively with parents, carers, youth workers, and people with intellectual disabilities. We have concerns about the inadequate levels of preparation and support for carers in many settings to understand and address the sexual and reproductive health needs of vulnerable young people in institutional care settings, particularly LGBTQI youth.

2.10 If we are serious about meeting the sexual health needs of young people, the quality of sexuality education that young people receive in both school and non-formal settings should be assured through curriculum design, training, monitoring and evaluation and robust systems of accountability. In practice, however, it is frequently the knowledge and commitment of individual teachers, principals, youth workers or carers, rather than robust systems and structures that determine whether young people's sexual and reproductive health is adequately addressed.

3. Comprehensive sexuality education

Definition

3.1 The United Nations Educational, Scientific and Cultural Organization (UNESCO), the UN specialised agency for education and the education sector, defines comprehensive 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.[3]

Values

3.2 Sexuality education should contribute to the formation of a fair and compassionate society by empowering individuals and communities, promoting critical thinking skills and strengthening young people's citizenship. It must provide learners with opportunities to explore and nurture positive values and attitudes towards sexual and reproductive health, and to develop self-esteem and respect for human rights and gender equality. It should empower young people to take responsibility for their own decisions and behaviours, and the ways in which they may affect others. It should aim to build skills and attitudes to enable young people to treat others with respect, acceptance, tolerance and empathy, regardless of their ethnicity, race, social, economic or immigration status, religion, disability, sexual orientation, gender identity or expression, or sex characteristics.

3.3 Evaluations of comprehensive sex education programs show that these programmes can help young people delay onset of sexual activity and increase condom and contraceptive use. Sexuality education – in or out of schools – does not increase sexual activity, sexual risk-taking behaviour or STI/HIV infection rates[4]. Sexuality education has positive effects, including increasing young people's knowledge and improving their attitudes related to sexual and reproductive health and behaviours.[5] Conversely, programmes that promote abstinence-only have been found to be ineffective in their stated aims of delaying sexual initiation, reducing the frequency of sex or reducing the number of sexual partners and potentially harmful to young people's sexual and reproductive health and rights.[6]

Content

3.4 The content of sexuality education must be based on facts and evidence related to sexual and reproductive health, sexuality and behaviours. It is critical that it is incremental and age-appropriate, with topics introduced gradually, so that it is responsive to the changing needs and capabilities of the child and the young person as they grow. It should be included within a written curriculum that guides educators' efforts to support students' learning. The curriculum must include key teaching objectives, learning objectives, presentation of concepts, and the delivery of clear key messages in a structured way.

3.5 Comprehensive sexuality education must address sexual and reproductive health issues, including, but not limited to: sexual and reproductive anatomy and physiology; puberty and menstruation; reproduction, modern contraception, pregnancy and childbirth; and STIs, including HIV and AIDS. Topics must be dealt with comprehensively and consistently and must be delivered to learners over time, throughout their education, rather than a one-off lesson or intervention.

3.6 As well as content on reproduction, sexual behaviours, risks and prevention of ill health, it is critical that sexuality education provides an opportunity to present sexuality in a way that includes its positive aspects, such as love and relationships based on mutual respect and equality. Sexuality education should promote the right to choose when and with whom a person will have any form of intimate or sexual relationship; the responsibility of these choices;

and respecting the choices of others in this regard. This choice includes the right to abstain, to delay, or to engage in sexual relationships.

3.7 Sexuality education must address safer sex, preparing young people for intimate relationships that may include sexual intercourse or other sexual activity. Education about consent is critical for building healthy and respectful relationships. And it is essential for young people who plan to have, or are already having sexual intercourse, to receive information about the full range of modern contraception, including the dual protection against pregnancy and STIs provided by condom use. A key goal of sexuality education should be contraceptive use at first sex. This requires understanding of specific risk and protective factors that affect particular sexual behaviours and skills to manage specific situations that might lead to STI, unwanted or unprotected sexual intercourse or violence. Young people must also learn about the supports available for sexual and reproductive health (e.g. counselling, testing and treatment for STIs/HIV; services for modern contraception, sexual abuse, rape, domestic and gender-based violence, abortion and post-abortion care and stigma and discrimination).

3.8 Sexuality education must address the needs of young people who are particularly vulnerable and disadvantaged, including, but not limited to: young people who are incarcerated or live in institutions or in direct provision centres; young people living in poverty; lesbian, gay, bisexual, transgender and intersex young people; and young people with disabilities.

Delivery

3.9 International research on sexuality education bears out the IFPA's experience and suggests that the delivery of sexuality education is as important as its content, and that acceptability to young people is critical. A 2016 synthesis[7] of qualitative studies of young people's views of their school-based sexuality and relationships education from 10 countries, including Ireland, found that schools appear to have difficulty accepting that some young people are sexually active, leading to relationships and sexuality education that is out of touch with many young people's lives. Furthermore, the report found that although sex is a potent and potentially embarrassing topic, schools appear reluctant to acknowledge this and attempt to teach relationships and sexuality education in the same way as other subjects.

3.10 Young people express dislike of their own teachers delivering relationships and sexuality education due to blurred boundaries, lack of anonymity, embarrassment and poor training. To ensure that young people do not disengage from relationships and sexuality education and opportunities for safeguarding and improving their sexual health, therefore, relationships and sexuality education should be 'sex-positive' and delivered by experts who maintain clear boundaries with students. Schools should acknowledge that sex is a special subject with unique challenges, as well as the fact and range of young people's sexual activity.[8]

3.11 Recent (2017) research from the UK highlights particular challenges in delivery of sexuality education. One the one hand, delivery by teachers supports the sustainability of programmes and enhances school capacity in this area. On the other, sexuality education requires particular qualities, knowledge and experience: those who deliver relationships and sexuality education should be trained educators, have expertise in sexual health, and be sex-positive and enthusiastic about delivering relationships and sexuality education. Young people may also be more willing to trust in confidentiality if programmes are not delivered by staff who are familiar to students as form or subject teachers. In addition, external sexual health professionals should be involved in delivering relationships and sexuality education and close liaison should be maintained with relevant sexual health and advice services.[9]

3.12 The quality of sexuality education is enhanced by systematic involvement of young people, which ensures that education is needs-oriented and grounded in the contemporary realities of young people's lives. Ensuring that young people have an active role in developing, evaluating and improving curricula should be a priority.

4. Sexuality education in Ireland

4.1 A key goal of the National Sexual Health Strategy 2015-2020 is that everyone living in Ireland will receive "comprehensive and age-appropriate sexual health education and/or information and will have access to appropriate prevention and promotion services".[10] However, the provision of sexuality education in Ireland remains patchy and inconsistent.

4.2 Relationships and Sexuality Education (RSE) was introduced in 1997 and has been mandatory at primary and post-primary junior-cycle since 2003. Guidelines on the content of sexuality education[11] have been produced by the National Council for Curriculum and Assessment (NCCA), however they are not compulsory and schools can decide how to teach the content of the course based on moral or ethical considerations.

4.3 The Department of Education requires that all schools have a policy regarding the teaching of RSE and that it is taught from the beginning of primary school to the end of secondary school. According to the Department, the RSE policy should reflect a school's core values and ethos as outlined in its mission statement. While no aspect of the RSE programme can be omitted on the grounds of school ethos, the Department has stated that all elements of the programme "can and should be taught within the ethos and value system of the school as expressed in the RSE policy".[12] In practice, this means that not all schools provide comprehensive information on the full range of contraceptive methods.[13] Due to the departmental requirement, the provision of sexuality education is hugely varied and depends on the ethos and value system of individual schools.

4.4 Research (2007; 2010; 2017) on the implementation of RSE indicates that, in many schools, teachers may not feel adequately trained to deliver certain aspects of the programme. To bridge the gap, they can invite in external groups. While this includes organisations such as the IFPA which provides comprehensive sexual health information, conservative Christian agencies, such as Pure in Heart, which advocate abstinence from sex until marriage and do not provide comprehensive sexuality education also deliver presentations in schools. In addition, the textbooks on which staff rely to deliver RSE may have been produced by an individual or organisation that focuses exclusively on heterosexual relationships and wishes to promote abstinence until marriage.

4.5 There is a lack of transparency surrounding RSE that is not found in other areas of the curriculum. For example, there is currently no register of outside groups and individuals that deliver RSE content in schools and schools are not obliged to inform parents about visits from external agencies. Although the Department of Education has produced best practice guidelines regarding visitors to post-primary schools in the context of RSE, these external organisations are not vetted or inspected by the Department.

5. Legal Barriers

5.1 According to the Health Behaviour in School-aged Children Report 2014, 31% of 15-17 year-old boys and 21% of 15-17 year old girls report that they have ever had sex.[14] Of those who report ever having had sex, 73% reported condom use; with 31% of boys and 35% of girls reporting use of the contraceptive pill.

5.2 The law regulating access to contraceptives for adolescents is very unclear because the age of medical consent is 16 but the age of sexual consent is 17. The situation is further complicated by the fact that the law does not explicitly prohibit healthcare providers from delivering services to girls under the age of 16. These legal ambiguities can give rise to scenarios such as medical professionals refusing to provide sexual health services (including emergency contraception) to young people or doctors violating principles of confidentiality by contacting the young person's parents against their express wishes.

5.3 A 2011 report[15] by the Law Reform Commission recommended legislative reforms to allow for the views of mature teenagers to be taken into account in the context of consenting to or refusing medical treatment. The Commission recommended that young people under the age of 16 should be able to give their consent to medical treatment based on an assessment of their maturity and the presumption that their parents will usually be involved.

5.4 Legal barriers also remain with respect to the sexual and reproductive rights of people with intellectual disabilities. The recent repeal of Section 5 of the Criminal Law (Sexual Offences) Act 1993, which made it an offence to have sex with a "mentally impaired" person outside of marriage, is a welcome development. However, it is of concern that the new Criminal Law (Sexual Offences) Act 2017 failed to take a disability neutral approach and instead categorises someone with an intellectual disability as a "protected person".[16]

6. Research on RSE

6.1 There is a lack of national monitoring and evaluation to accurately assess the effectiveness of the RSE programme. A 2013 study on the implementation of RSE found that practices and procedures to support planning for senior cycle RSE were not effective in the majority of schools – there were evident weaknesses in programme planning for senior cycle RSE in 62% of the 63 post-primary schools inspected.[17] Earlier studies (2007; 2010) have also identified problems with the implementation of RSE at senior cycle level.[18] Research (2003; 2007) also indicates that the time allocated to RSE decreases substantially once students reach third year of junior cycle.[19]

6.2 Studies (2007; 2010) suggest that many RSE teachers do not feel sufficiently trained or supported to teach the subject matter, which indicates that the training and support provided by the SPHE Support Service may need to be revised. According to the 2015 Lifeskills Survey, a majority of primary schools find teaching RSE either challenging (62%) or very challenging (12%).[20] And a majority of post-primary schools reported that teaching RSE is either challenging (62%) or very challenging (16%). Youthreach Centres ranked RSE as the second most challenging subject to teach—only mental health is considered a more challenging subject than RSE. Young people surveyed for the 2010 Lifeskills Survey recommended that teachers be better trained to deliver RSE, citing concerns that some teachers do not take the subject seriously or are afraid or embarrassed to talk about sex.[21]

6.3 Accord (the Catholic Marriage Care Service) is one of the most frequently used external facilitators for RSE delivery in primary schools. At post-primary level, Cura (Catholic pregnancy counselling service) is among the most widely used external agencies for RSE delivery.

6.4 In 2016, the HSE and Tusla published a report about the sexual health and sexuality education needs of young people in care.[22] It recommended that RSE should be made available to young people in care in their care setting as well as at school; however, the current provision of RSE varies greatly within and across care settings. The report also found that

more consistent training opportunities in RSE are required for social workers, social care workers and foster carers and RSE policies are needed in residential centres to promote the consistent delivery of RSE.

Recommendations

1. The recommendation of the United Nations Committee on the Rights of the Child to develop a comprehensive sexual and reproductive health policy for adolescents should be implemented.

2. Guarantee the right of all young people to receive factual and objective information on relationships and sexuality regardless of schools' ethos.

3. The Department of Health guidelines on relationships and sexuality education should be revised to reflect international best practice in the provision of age-appropriate comprehensive sexuality education: i.e. based on facts and evidence related to sexual and reproductive health, sexuality and behaviours.

4. Topics should be introduced gradually and delivered incrementally in an age-appropriate manner that is responsive to the changing needs and capabilities of the child and the young person as they grow. A minimum number of hours per term should be allocated to sexuality education programmes in schools.

5. A clear set of goals and indicators for sexuality education should be established within the curriculum, including contraceptive use at first sex as a goal, with indicators measuring delivery of information about pregnancy, contraception and STIs.

6. Develop a robust system of inspection of sexuality education in schools, and provide training for school inspectors on the monitoring and evaluation framework.

7. Consultation with key stakeholders in the development of a revised CSE strategy should be a priority in the revision of the guidelines: youth organisations, school councils, sexual health organisations and experts, parents' organisations, teachers and experts on human sexuality, behaviour change and related pedagogical theory.

8. Encourage a whole school approach to the development of school policy on sexuality education involving Board of Management, parents, student councils and other key stakeholders, and in consultation with experts in sexual and reproductive health.

9. Train and resource specialist sexuality educators—including, but not limited to primary and secondary level teachers—who can deliver comprehensive sexuality education in schools, youth groups, care homes and other settings.

10. Take measures to ensure that RSE is available, and delivered by specialist sexual health educators, to young people in care, including incarcerated young people and young people with intellectual disabilities, in their care setting, as well as at school.

11. Provide a network of non-formal settings, such as Youth Cafes, where young people can access sexual and reproductive health information and services.

12. Develop a quality assurance framework for comprehensive sexuality education to ensure that implementation of sexuality education in schools and in non-formal settings can be robustly monitored and evaluated.

13. Remove the legal barriers to access to contraception by young people.

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