Informing Choice

New Approaches and Ethics for
Sex and Relationships Education in Scotland

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A Report by
The Scottish Council on Human Bioethics

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Part 2: Ethics

Introduction
The Incorporation of Ethics into Sex and Relationship Education

1. The debate surrounding teenage sexual activity takes place in one of the most politicised arenas of Western culture. Scotland, in this respect, is little different from many other countries in which sexual activity is considered both as a positive relationship but also as the source of a number of problems, especially with respect to teenage sexuality. Indeed, sexual activity amongst young people has been associated with a whole series of difficulties.

2. First of all, teenage sexual activity may lead to pregnancies that may be related to a number of disadvantages, both for the mother and for the child. For example, girls who become pregnant are unlikely to have the kind of extended family support they once had in past generations. Moreover, negative social consequences may exist if the adolescent does not have support from the father. The mother is therefore more likely to rely on financial support, either from her own parents or from government sources. In addition, there are significant social costs involved in teenage motherhood. Educational attainment and achievement is often the main avenue for progress within western society. Without such attainment, poverty and limited opportunities to progress in life are much more likely.

3. Secondly, teenage sexual activity may lead to unintended pregnancies and regret, with all the related psycho-emotional distress that this may cause. Many teenagers are, indeed, too young and immature to adequately understand all the complex issues associated with sexual relationships.

4. A third problem is the rapid rise in the numbers of sexually transmitted infections (STIs) which have been described by some public health officials as a *'crisis'* with health services being stretched to their limits. The figures are well known. Chlamydia, an STI that can lead to infertility in girls, has increased from 7654 diagnoses in 2000 to 12,392 in 2002. Genital warts, part of a group of viruses that have been significantly linked to the later development of cervical cancer in women, have also increased (see Chapter 1, Section 1.2.2). These figures represent a major public health problem.

5. In order to study and seek to address these difficulties, the following report has been divided into different chapters:

6. Part 1 of this report discusses the Scottish context and studies the reasons why teenagers initiate sexual activity while examining some important international case studies.
   Chapter 1 is a consideration of the Scottish sexual health scene and a look at the legislative and policy framework. It considers a number of initiatives that have been taken in an attempt to improve sexual health in Scotland.
   Chapter 2 consists of a review of the reasons behind the initiation of teenage sexual activity in order to identify areas that require attention and looks for new approaches to sexual health promotion.
   Chapter 3 consists of three case studies drawn from international experiences and considers approaches to sex education that may provide lessons for Scotland.

7. Part 2 of the report considers the incorporation of ethics into sex and relationships education (SRE).
   Chapter 4 presents the relevant ethical principles in the context of SRE.

Chapter 5 applies these ethical principles within SRE and wider sexual health promotion in Scotland and makes a number of recommendations as to the manner in which this may be achieved.

8. The report crucially argues that the ethical principles used in health care settings, including the principle of *Informed Choice* need to be fully integrated into SRE. Unfortunately, sex education in Scotland often uses ethical language and principles such as *'informed choice'*, *'best interests'*, *'freedom of choice'* and *'rights'* but rarely expands these principles in full. This report seeks to address this failure.

9. There is a crucial need for Scotland to move forward and build a collaborative strategy between different actors such as parents, schools and local authorities in this divisive and contentious area. The full application of ethics should build confidence between parents and sexual health professionals and provide a basis of agreement.

10. Ethics also supports the young person's right to all the necessary information they require in order to make informed choices. The report makes a number of suggestions where more information and understanding on behalf of the young person are required in order for SRE to promote genuine informed choice.

Part 1
Setting the Scene

Chapter 1
The Scottish Situation

1.1 Introduction

11. This chapter details the extent of the current sexual health problem in Scotland. It summarises the various initiatives that have been taken in an attempt to address this problem. The wider policy context within which these initiatives are set is also detailed. The chapter argues that these initiatives and the policy context have largely focused on improving access to sexual health services with a particular emphasis upon providing information and contraception. It concludes that a much more comprehensive approach is required that is based as far as possible on consensus, that the legal framework to achieve this for SRE already exists in Scotland and that this needs to be fully implemented.

1.2 Scotland's Sexual Health

1.2.1 Teenage Pregnancy

12. The UK has the highest rate of teenage pregnancy in Western Europe. According to a recent UNICEF report studying 28 rich nations, the UK is second only to the USA in terms of its teenage birth rate (UNICEF, 2001). Statistics on teenage pregnancy in Scotland published in 2002 show that amongst 13-15 year-olds the rate of pregnancy is 7.2 per 1000 and amongst 16-19 year-olds the rate is 68.1 per 1000. The figures have been steadily decreasing since 1996, although Scotland remains well above levels in other western European countries. In 2002 East Renfrewshire Council area recorded the lowest rate of teenage pregnancy for 13-19 year-olds at 21.1 per 1000 and Dundee City Council recorded the highest at 59.1 per 1000 (ISD Scotland, Scottish Health Statistics).

1.2.2 Sexually Transmitted Infections

13. Sexually transmitted infections (STIs) are a major and growing concern in Scotland. Policy initiatives focus heavily on both prevention and harm-minimisation. The current statistics for some STIs are outlined below.

HIV Infections

14. In the UK new HIV infections continue to rise with 5542 new diagnoses in 2002, which is almost double that of the 2814 diagnoses in 1998. In Scotland there has been a worrying increase in HIV infections from 154 in 1998 to 250 in 2002. Much of this increase was in Lothian and Greater Glasgow Health Board areas (SHOW Scotland www.show.scot.nhs.uk/scieh/ (Table A2)). The number of people diagnosed with HIV who are currently being treated in Scotland is 1572. Of these 546 are identified as men who have sex with men, 504 are heterosexual men and women and 391 are injecting drug users. Other exposure categories including through blood products and transmission from mother to infant account for 131 cases (HPA, 2003). It should be noted that there have been increases in HIV infection among young people in Scotland who have no other risk factors: drug use or homosexuality. Such increases are worrying considering the spread of HIV among heterosexual populations in other parts of the world and the potential for increased international transmission of the virus.

Genital Chlamydia Infections

15. Chlamydia is of great concern in Scotland. Diagnoses of genital Chlamydia trachomatis infection have risen in Scotland from 7654 in 2000 to 12,392 in 2002 (HPA, 2003). Diagnoses of STIs in GUM clinics have more than doubled since 1995. There has been a 66% increase in the diagnoses among women under 16 years of age (Scottish Executive, 2003, Supporting Paper 1). This may be partly due to increased awareness and testing. However, this is unlikely to explain all the new infections and increases in high-risk sexual behaviour are also likely to be a factor.

16. Chlamydia is asymptomatic in up to 70% of female cases and 50% of male cases. The true rate of infection is therefore likely to be much higher with many people unaware of the infection. One recent study carried out in Scotland among 800 male army recruits found that 78 were infected (Scott et al, 2003). The report highlighted the fact that these men were generally not those who would be deemed to be at high risk according to the number of partners they had had in the last six months. Of these 78 men, 69 showed no signs of being infected suggesting much higher rates of infection without a symptom. These figures have been supported by other studies which have suggested that one in ten young people are likely to have Chlamydia. Chlamydia infections can develop into pelvic inflammatory disease that can increase the risk of ectopic pregnancy and cause infertility in women.

Gonorrhoea

17. In Scotland there were 821 reports of Gonorrhoea in 2002. This is compared with 817 in 2001 and 539 in 1999. The majority of these were in Greater Glasgow and Lothian which saw a 55% increase and an 83% increase in diagnoses respectively between 1999 and 2002. Gonorrhoea is a disease that is more common in areas of urban deprivation and amongst population sub-groups such as men who have sex with men, young women and black and ethnic minorities. There is antimicrobial resistance to Gonorrhoea that adds to concern and makes adverse consequences of Gonorrhoea more likely (HPA, 2003).

Syphilis

18. In the UK between 2001 and 2002 diagnoses of Syphilis rose by 73% in males and 33% in females, along with a rise of 75% among men who have sex with men. The burden of this disease does not rest on teenagers but upon older age groups. Of the diagnoses in Scotland 79% were among men having sex with men (Scottish Executive, 2003, Supporting Paper 1). A matter of concern is that there have been recent outbreaks of Syphilis in Edinburgh and Glasgow (HPA, 2003). The increase in diagnoses of Syphilis may be due to an increase in testing of HIV positive individuals, in addition to an increase in high-risk sexual behaviour (HPA, 2003).

Anogenital Warts and Humanpapillomavirus (HPV)

19. Anogenital warts are caused by the humanpapillomavirus (HPV) of which there are over 90 different genotypes. Most anogenital warts are benign, usually caused by types 6 and 11. Since many HPV infections are not visible, warts represent only a small proportion of the total number of infections (Maw et al 2002). Between 1994 and 2000 first occurrence of anogenital warts among females and males increased from 4,700 to 5,433, and recurrence rates of the infection rose from 1781 to 2382 (Scottish Executive, 2003, supporting paper 1).

20. HPV types 16, 18 and 31 are thought to be the main cause of cervical cancer in 99% of cases and responsible for up to 50% of vulval cancers. There are clearly other factors that increase the risk of cancer, e.g. smoking (Monoz et. al 2003).

21. A major review of scientific evidence for condom effectiveness in June 2000 concluded: *'there was no evidence that condom use reduced the risk of HPV infection,..'*. There is no reliable way of preventing HPV; condoms help but are extremely limited in their ability to prevent an infection that can be passed on through contact with the whole genital area, the perianal area and inner thighs (NIH, 2001). The growing prevalence of HPV and its possible consequences suggests that a more concerted focus should be given to preventing the spread of HPV among young people.

1.2.3 Abortion

22. Many women in Scotland experience unplanned or unwanted pregnancies. Among 13-15 year-olds, birth and abortion rates have remained stable over the last 12 years, with a birth rate of 3.1 per 1000 women and an abortion rate of 4.2 per 1000 women. For 16-19 year-olds in 2002, the birth rate was 40 per 1000 women and the abortion rate was 28.1 per 1000 women (ISD Scotland, 2003). The Lothian national health demonstration project, Healthy Respect, has a target of reducing the rate of abortions among young women by 50% by 2010 (see Section 1.4.1). This reflects the commitment to reducing the rate of unwanted pregnancy throughout the UK. As yet a reduction in teenage pregnancy has not been observed. However, it is important to look at trends rather than year on year statistics particularly when numbers are initially low.

1.3 Scottish Sexual Behaviour

1.3.1 Analysis of the National Survey of Sexual Attitudes and Lifestyles (2000)

23. The National Survey of Sexual Attitudes and Lifestyles (NATSAL) in 2000 was carried out for the whole of Britain on 16–44 year-olds. The data for Scotland was analysed giving a sample of 856 people, 368 of which were men and 488 were women (Macdowall et al, 2002). A brief summary of some of the key statistics follows.

Sources of information about sexual matters for 16-29 year-olds

24. In terms of the sources of information that young people have and want, the sample showed the following: For women **the main sources of information about sexual matters were**: friends of their own age (25.2%), school lessons (22.3%), parents (22%) and media (14%). For men, the main sources were friends of own age (32.3%), lessons at school (26.8%), media (14%), first sexual partner (13.8%) and parents (11.2%).

25. **The main types of information they wanted on sexual matters were:** for men *'sexually transmitted infections'*(46%), *'sexual feelings and relationships'* (44.5%) and contraception and birth control (26.8%). For women sexual feelings and relationships (43.7%), sexually transmitted diseases (38.5%) and contraception and birth control (29.2%). It is gratifying that the Scottish Executive now refer to sexual health and relationship education rather than sex education since young people clearly want more information about relationships. Adequate attention must be given to what is meant by *'relationships'* and the scope of this topic recognised (see Chapter 4, Section 4.3.1 (b)).

26. In terms of **preferred sources of additional information:** 41% of men said school lessons with the next highest category being parents (32%). For women the preferred sources were parents (46%) and school (33%). Other categories were considerably lower in popularity including first partner and doctors/nurses. These statistics support the importance of parents and schools in their role as educators of young people in relation to sexual health.

First sexual experiences 16-29 year-olds: Heterosexuals

27. **Average age at first intercourse** in this study was 16 for both sexes. Some 29.7% of men and 22.8% of women experienced sex before 16 years of age.

28. A measure of ***'Sexual Competence'*** was devised, based on a number of factors. These included: whether the person was willing and consented to sex; the nature of the relationship with the partner – i.e. whether, for example, they had just met; the age at intercourse and therefore experiences of regret; and finally, whether or not contraception was used. It was found from this sample that only 53% of men were considered competent at first intercourse, and 41.6% of women. Competence, according to this particular measure, appears to be worryingly small and a cause of great concern. This may reflect the greater risk activity associated with early experiences of sex among younger teenagers (see Chapter 4, Section 4.3.3.).

29. **Experienced regret at first intercourse:** For young men the regret of first intercourse was 41.8% for 13 or 14 year-olds, 26.3% for 15 year-olds, 19% for 16 year-olds and 11.8% for 17 year-olds. In contrast, for girls the experience of regret of first intercourse was 84.3% for 13 or 14 year-olds, 49.1% for 15 year-olds, 34% for 16 year-olds and 33.8% for 17 year-olds.

30. **The two factors highlighted as contributing to the main reasons for first sexual experience were: peer pressure and drunkenness**. For men peer pressure was cited by 9.2% of 13 or 14 year-olds, 9.9% of 15 year-olds, 8.1% of 16 year-olds and 8.8% of 17 year-olds. For girls the corresponding figures are 13% for 13 or 14 year-olds, 13.7% of 15 year-olds, 7.4% of 16 year-olds and 4.8% of 17 year-olds. Drunkenness was cited by men as follows: 11.8% of 13 or 14 year-olds, 6.7% of 15 year-olds, 3.8% of 16 year-olds and 12.1% of 17 year-olds. For women the figures were 6.9% for 13 or 14 year-olds, 7.4% of 15 year-olds, 5.5% of 16 year-olds and 4.7% of 17 year-olds.

Sexual attraction and experience of 16-29 year-olds

31. Among men 93.8% were only attracted to the opposite sex, 1.1% only ever attracted to the same sex and 5.1% attracted more often to the opposite sex but at least once to the same sex. For females 91.3% were only attracted to the opposite sex, 0% were attracted only to the same sex, 0.8% to the same sex but at least once with the opposite sex, and 7.4% more often with the opposite sex but at least once to the same sex.

32. The study estimates that 10% of men and 6% of women aged between 16 and 44 had concurrent sexual partners in the year prior to being interviewed. Other statistics of interest are that 5% of Scots aged 16 to 44 reported engaging in unsafe sex and that nearly 20% of Scottish men and 10% of Scottish women had sex with someone for the first time when they were outside the UK.

Attitudes to sexual behaviours among 16-19 year-olds

33. Sex before marriage was considered *'rarely/not at all wrong'* for 86.5% of men and 88.1% of women. For sex outside marriage it was *'always/mostly wrong'* according to 87.6% of men and 86.8% of women. One-night stands were *'rarely/not at all wrong'* for 41.8% of men with 26.7% saying they were *'always/mostly wrong'*. 44.8% of women said one night stands were *'always/mostly wrong'* and 29.3% said they were *'sometimes wrong'*.

Lessons from NATSAL

34. The NATSAL study shows that peer pressure and alcohol are both key factors leading to first sexual intercourse. It is important, therefore, that initiatives that are taken to address Scotland's sexual health problems recognise these factors and seek to address them. Regret remains a problem especially for girls. And for many people sex may promise more intimacy than it provides in practice. This suggests that the relationship between non-sexual needs and regret (as discussed in Chapter 2, Section 2.2.1.) requires more research. The study also shows low levels of sexual competence at first intercourse. Risky behaviour remains strong amongst a minority of Scots. A small, but nevertheless significant, minority of Scots are estimated to have had concurrent sexual partners in the year prior to being interviewed. A more significant proportion of Scots, but nevertheless still a minority, report engaging in unsafe sex. There is an increased willingness for Scots to view sex prior to marriage as acceptable behaviour and this may reflect a general shift away from traditional religious commitment in Scottish society. However, it is interesting to note that young people have strong feelings about fidelity within marriage. Marriage, monogamy and fidelity are all topics that should be addressed within a program of SRE.

1.4 Some Recent Initiatives

1.4.1. Healthy Respect

35. The Healthy Respect project is one of three health demonstration projects set up as a result of the 'Towards a Healthier Scotland' report in 1999 (see Section 1.5.1). Healthy Respect is based within the Lothian NHS Board and is funded with over £1m a year from the Scottish Executive. Its targets are:

- **Teenage Pregnancies**: To reach the target set by Towards a Healthier Scotland (1999) of reducing the rate of teenage pregnancies among 13-15 year-olds by 20% between 1995 and 2010. There is also an aim to reduce termination of pregnancy rates by 50% by 2010 without increasing the birth rate.
- **Sexually Transmitted Diseases**: To reduce the reported prevalence of Chlamydia among young people in Lothian by 50% by 2010. It is anticipated that the incidence of Chlamydia will rise initially as the project endeavours to raise awareness and increase testing.
- **Self Esteem and Confidence** is correlated with sexual risk-taking behaviour. The Healthy Respect initiative will seek to increase self-esteem among young people so that they might demonstrate respect for themselves and others.

36. Healthy Respect states that it is committed to the UN Convention on the Rights of the Child (Powers, 2003) and as such *'young people should have access to accurate sexual health and relationships information.'* It adopts a harm minimisation approach (see Chapter 5, Section 5.1.3.) believing this to be the most effective way to reduce teenage pregnancies and the spread of STIs (Powers, 2003). The Healthy Respect team are working with a number of partner organisations and aim to reach all young people in Lothian. There are however a number of particular groups that have priority. These are: young people in care; parents; young men; and marginalised young people. Young people in care are considered to be particularly vulnerable in terms of sexual health. Parents and the home environment are seen as a vitally important influence on young people. The focus on young men is intended to redress the balance in which sexual health work has tended to concentrate on girls. Marginalised young people are being targeted because social isolation is linked to unsafe sexual practices.

37. To meet these aims Healthy Respect is working in the following areas: informal youth settings; schools; further education colleges; hospitals/primary care settings; and voluntary organisation premises. Across Lothian there are 12 projects underway. These include: the use of postal testing kits for Chlamydia in non-healthcare settings e.g. music shops, sexual health promotion in further education colleges including provision of free condoms, toilet advertising and Chlamydia testing. Also included is: the use of SHARE (Sexual Health and Relationship Education) to provide SRE training for teachers and other professionals, helping parents discuss sexual health with their children, and utilizing the mass media to promote positive sexual health messages (Lothian NHS Board).

38. The Dugald Baird Centre for Research on Women's Health at the University of Aberdeen is currently conducting an evaluation of the Healthy Respect Project. It will report at the end of the first 3 year phase of the project. It is too early to make this assessment and the jury is still out on the effectiveness of Healthy Respect. However, at present there is no evidence of improvements in either sexual health or in the teenage pregnancy rate in Lothian. Between 2000 and 2002 the teenage pregnancy rate in Lothian among 13-15 year-olds has increased from 8.1 per 1000 young women to 8.4 per 1000. The number of these pregnancies that end in delivery has fallen from 54 per 1000 young women to 45 per 1000, while at the same time the abortion rate has increased from 55 per 1000 young women to 67 per 1000 young women (www.isdscotland.org/). In terms of sexual health the number of people diagnosed with Chlamydia more than doubled in the Lothians, with an increase from 1207 to 2744 new cases in 2002 (Scotsman 15th July 2003). The increase in Lothian is likely to arise in part from the increased testing resulting from Healthy Respect, but may also be because of increased risky sexual behaviour. It is only when statistics become available over the longer term that an accurate analysis of the effect of Healthy Respect will be possible.

1.4.2. Sexual Health and Relationships Education: Safe Happy and Responsible (SHARE)

39. In Scotland, the most important sex education program is SHARE which is produced by the Health Education Board for Scotland (HEBS). It was initially piloted in 1994 and 1995 and then further developed. It is now being used in a number of locations and specifically in 10 schools that are part of the Healthy Respect demonstration project. The material consists of twenty sessions. It is aimed at S3/S4 (13-15 year-olds) and has sought to be both research led and needs led in its development. It has drawn on both educational and psycho-social theory in its development, in addition to incorporating existing educational material alongside research into young people's behaviour. There is a comprehensive multi-agency program for those who wish to teach the material in schools.

40. The values underpinning the program are stated as:
    - *Our sexuality is a natural and healthy part of who we are.*
    - *Each of us feels differently about our sexuality, and we may express it in different ways.*
    - *We should treat each other as we should like to be treated.*
    - *We should never have to do anything sexual we don't want to do.*
    - *If we choose to have sex, we should protect ourselves and sexual partners from unwanted pregnancy and from sexually transmitted infections.*
      (Dixon, 2003)

41. The approach of the SHARE program and therefore the values it communicates are found in the training manual under the section '*Exploring Approaches to Sex and Relationships Education'*. The SHARE approach is described as being closest to the '*prescriptive model'* in a values continuum that also describes the '*proscriptive', 'passive'* and '*personalised'* approach to SRE. The '*Prescriptive'* approach is described as:

> *'… the perspective of those who recognise that we live in a pluralistic society where there are many different lifestyles. They believe in people's right to lead their own life, whilst also believing that young people need to be protected and guided. Such people argue for sex education which gives young people good information, moral frameworks and skills to resist pressure and make good decisions for themselves; recognises that some young people are and will continue to be sexually active; and promotes risk reduction strategies including safer sex and condom use. It attempts, among other things, to change beliefs, norms and behaviours. This is closest to the model used by SHARE.'* (Dixon, 2003).

42. Results from a randomised controlled trial between 1996 and 1999 in 13 school locations reveal the limitations of SHARE in changing behaviour. The study showed that there was no reduction in either sexual activity or in sexual risk taking among adolescents in the SHARE group when compared with the control group. Nor was there any increase in condom use at first intercourse under the program or a reduction in unwanted pregnancies. However, there was a reduction in regret among those young people who had more than one partner. The interpretation of these findings were that condom use was surprisingly high in both the intervention group and in the control group, suggesting that further increases in condom use would be very difficult to achieve. Also, it was suggested that the limits of teacher-delivered sex education to influence the behaviour of young people may have been reached:

> *'The results imply that the potential for teacher delivered, whole class sex education to influence sexual behaviour in adolescents might have already been reached by conventional provision. If behavioural change among this age group is a central objective of school sex education then it should be further refined and other means of delivery should be rigorously evaluated.' (Wight et al, 2002).*

43. If the limits of teacher-delivered sex education have been reached, then new approaches are needed to either make sex education more effective or, alternatively, to focus on other efforts apart from sex education to improve Scotland's sexual health. Developing a peer-led sex education program like, for

example, the A Pause program in England may be one option (see Mellanby et al. 1995). Alternatively Wight and Abraham in a paper called *From Psycho Social Theory to Sustainable Classroom Practice* (Wight and Abraham, 2000) discuss the theoretical basis of the SHARE program and the issues of the application of theory into the classroom context. They express how much practice in getting and using condoms is important to the SHARE program in its efforts to improve sexual health. This includes giving young people the skills to handle and use condoms effectively, help in where to get condoms, and even visits to clinics, all for the purpose of overcoming embarrassment in acquiring contraception. Visits to clinics are limited because of cost and time limitations. However, the importance of ease of access and acquisition of condoms are areas where progress is seen as needed in the outworking of the SHARE program in schools (Wight and Abraham, 2000). This very much reflects the emphasis in the Scottish Executive's current draft Sexual health strategy of increasing access to contraception and linking clinical services to schools. This is an explicitly harm-minimisation approach.

44. It is important however to note the lack of evidence base for the effectiveness of linking contraception services to school-based SRE programs to either reduce teenage pregnancy or STI rates. If young people are going to have sex, condom use would be important, but as a major measure to improving sexual health there is a significant lack of reliable evidence. An influential review paper from the NHS Centre for Reviews and Dissemination suggested that linking contraceptive services to school-based sex education lessons can reduce teenage pregnancy (NHSCRD, 1997). However, this paper has been criticised when it is used as a basis of policy because it is based on observational studies rather than randomised controlled trials. This weakness has been noted by researchers (Wight et al. (2002) and Guyatt et al. (2000)). Further, important research from Kirby in the USA has stated that there is no evidence that increased availability of condoms and contraceptive services linked to schools and SRE programs reduces teenage pregnancy, or that contraception use substantially increased (Kirby, May 2001).

45. Due to the lack of evidence for the above approach, it is vital that future developments of the SHARE program are evidence-based. The SHARE program in the Scottish Executive's draft sexual health strategy is described as an abstinence-plus program (see Section 1.5.4). As will be seen from the international comparison section, and in particular the case study of the USA (Chapter 3, Section 3.3), abstinence-plus programs vary greatly in their content. The term 'abstinence' is often used with little emphasis on this aspect of the program. The SHARE program places minimal emphasis on delaying the onset of sexual activity. In light of the growing evidence from the USA demonstrating that encouraging delay can reduce sexual risk behaviour (see Chapter 3, Section 3.3), it is notable that SHARE does not provide more explicit information and reasons why delay may be beneficial. Douglas Kirby states two characteristics from his paper *Emerging Answers* on effective programs, he states: *'…effective programs shared two common attributes: (1) being clearly focused on sexual behaviour and contraceptive use and (2) delivering a clear message about abstaining from sex as the safest choice for teens and using protection against STD's and pregnancy if a teen is sexually active.'* (Kirby, May 2001). SHARE simply does not reflect the priority that abstinence has in the most effective programs. SHARE has only one session explicitly on delay, *'developing the skills to say "no"'*, out of a total of 20, which includes little if any explicit information and reasons why someone may want to delay sexual activity. The choice to delay is left to the individual, because of a desire not to impose morality. Future versions of SHARE should consider a more thorough incorporation of such information so that the positive reasons for delay are fully understood. Moreover, genuine informed choice through such information should be promoted and effective evidenced-based approaches should be considered (see Chapter 5, Section 5.1.4.).

1.4.3. Sexual Health and Wellbeing Learning Network

46. In January 2003, the Sexual Health Learning Network was launched by the Scottish Executive in order to help stop the dramatic rise in sexually transmitted infections. The Network also wants to reduce the rise in unwanted teenage pregnancies through developing a more open culture where people talk more about sex, are more liberal about the sexual health of other groups, and for teachers to be more satisfied with the material in schools (SHLN, 2003). The Network's remit and aims are:

- *To establish a support network of interested individuals and organisations to improve Scotland's sexual health,*

- *To prevent ill health by the promotion of good sexual health.*
- *To promote positive sexual health, using our own previous experiences e.g. from programmes like 'Healthy Respect', and the experiences of other countries.*
- *To bring together evidence of effectiveness of knowledge and translate into practice, to merge systematic evidence with practical know-how.*
- *To produce guidance resources.*
- *To act as a catalyst for change.*

1.4.4. Walk the Talk

47. Walk the Talk is a project funded by the Scottish Executive and managed by Youthlink Scotland and Fast Forward. It is designed to develop appropriate and accessible primary health care services for young people. It provides training for health practitioners and youth workers and networks by promoting other agencies providing youth health services across Scotland. The next phase of Walk the Talk will run until 2005. The project works closely with policy makers, practitioners of youth health services and training institutions (Walk the Talk, 2000).

1.4.5. Think About It?

48. 'Think About It' started as a Scotland-wide television campaign that challenged teenagers to consider their responsibility to make decisions about their health. In 2002 the Think About It website was launched by the Health Education Board for Scotland (HEBS) to encourage young people to think through the consequences of sex and relationships (www.hebs.com/thinkaboutit). The site is aimed at 14-17 year-olds, slightly above the target audience of the Lothian based Healthy Respect demonstration project. On the website young people are provided with information and are asked to consider some characters who are making decisions about sex and relationships. The young people are asked to consider how they would respond in given situations. The work of Healthy Respect has been used as a model for the new website (HEBS, May 2002).

1.5 Policy Context

1.5.1. Towards a Healthier Scotland (1999)

49. This paper was a development following on from the 1998 Green paper, *Working Together for a Healthier Scotland.* The paper focused on a few health priorities including heart disease, cancer, mental health and sexual health. With regard to sexual health the paper established the Government's headline target to reduce the pregnancy rate among 13-15 year olds by 20% between 1995 and 2010. To achieve this the demonstration project called Healthy Respect was to be set up to develop best practice in the promotion of sexual health and the prevention of unwanted teenage pregnancies. The aim was *'…[to] foster responsible sexual behaviour on the part of Scotland's young people with emphasis on the avoidance of unwanted teenage pregnancies and sexually transmitted disease.'* (Scottish Office, 1999).

1.5.2. Teenage Pregnancy (1999)

50. This highly influential paper produced by the Social Exclusion Unit for the UK Parliament provided additional advice on approaches that needed to be taken to achieve a reduction in teenage pregnancy. This paper was not specific to Scotland but it sought to provide an overview of the issues and problems associated with teenage pregnancy and give some answers. The report overviews promising approaches from the UK and abroad, and provided a three-pronged approach to the issue that would be adopted in England and Wales and Northern Ireland. (1) A national campaign to mobilise every section of the community, including local and central government, to achieve agreed goals. This national campaign was specifically for England, the approach being much later adopted in Scotland with the sexual health strategy finally arriving in late 2003. (2) Better prevention of the causes of teenage pregnancy through better

education about sex and relationships, contraception and attention on high-risk groups. (3) Better support for pregnant teenagers to finish education and help to prevent social exclusion. (SEU, 1999)

1.5.3. Legislative Context and Guidance

51. In late 1999 the Scottish Executive announced its intention to repeal Section 2A of the Local Government Act 1986, which prevented the promotion of homosexuality by local authorities. After an intense public debate the Scottish Parliament passed the Ethical Standards in Public Life (Scotland) Act, 2000 which included the repeal of Section 2A. Section 35 of this Act requires local authorities to have regard for:
    - *The value of a stable family life in a child's development;*
    - *The need to ensure that teaching and learning are appropriate to the child's age, understanding and development.*

1.5.3. (a) The Working Group on Sex Education in Scottish Schools Report (McCabe Report)

52. In February 2000, and in order to allay any fears and concerns on the part of parents or the wider public, the Executive set up the Working Group on Sex Education in Scottish Schools (also known as the McCabe Committee) to review the range of curricular advice available to teachers in relation to sex education. In June 2000 the Working Group recommended that to ensure good practice was maintained after the repeal of Section 2A, the Executive introduce a number of measures. These were:

    - *The issuing of strong, clear guidance to local authorities;*
    - *Advance consultation with parents by individual schools;*
    - *Simple direct procedures for parents to raise concerns;*
    - *A review of curriculum advice and supporting materials for schools and teachers.*

53. One of the key principles for sex education outlined in the McCabe Report, 2000, was that: *'Sex education starts informally at an early stage with parents and carers and continues through adulthood both within the home and at all stages of school life.'* (McCabe, 2000). This principle outlines the importance of parental involvement in SRE and challenges schools and local authorities to consider how they might utilise parents more effectively (see Chapter 5, Section 5.1.5.).

54. The Scottish Executive accepted the recommendations of the Working Group and asked Learning & Teaching Scotland to produce a number of resources for parents, schools and local authorities setting out guidance on the teaching of sex education and the importance of parental consultation. Learning & Teaching Scotland produced 5-14 Health Education – Guide for Teachers and Managers in 2000, and this document was supplemented by three further publications:

- **A Guide for Parents and Carers**: This document sets out what parents can expect from schools, their rights to know what is being taught to their children and the sharing of responsibility with parents in educating their children about sex.
- **Effective Consultation with Parents and Carers**: Sets out the legal framework for sex education in schools. It further outlines the need for schools to have effective links with parents regarding health promotion and of the principles of how schools and local authorities should consult with parents and respond to their concerns.
- **Summary of National Advice:** Outlines the role of sex education within the broader curriculum of schools. It provides sources of advice on what should be in the curriculum and also materials that may be appropriate for schools. The report also includes information on faith perspectives regarding sexual relationships and the conduct of sex education.

1.5.3. (b) The Standards in Scotland's Schools etc. Act, 2000

55. The Executive also introduced the Standards in Scotland's Schools etc. Act, 2000. Section 56 of this Act allows the Executive to issue guidance to local authorities regarding the conduct of sex education and requires local authorities to *'have regard'* for this guidance.

Circular 2/2001 – Guidance on the Standards in Scotland's Schools etc. Act, 2000

56. In March 2001 the Scottish Executive Education Department published this guidance in Circular 2/2001. This circular sets out the framework within which SRE should be taught in Scottish schools. The emphasis in the circular is on the need for sex education to encourage responsible and fully-informed decision making on the part of young people and an awareness of sexual health risks. The circular states:

> *"Programmes of sex education should present facts in an objective, balanced and sensitive manner within a framework of sound values and an awareness of the law on sexual behaviour. Pupils should be encouraged to appreciate the value of stable family life, parental responsibility and family relationships in bringing up children and offering them security, stability and happiness. Pupils should also be encouraged to appreciate the value of commitment in relationships and partnerships including the value placed on marriage by religious groups and others in Scottish society. At the same time, teachers must respect and avoid causing hurt or offence to those who come from backgrounds that do not reflect this value. All pupils should be encouraged to understand the importance of self-restraint, dignity, respect for themselves and the views of others. They should be encouraged to recognise the physical, emotional and moral implications and risks of certain types of behaviour and to accept that both sexes must behave responsibly."* (Circular 2/2001, Para 7)

57. Circular 2/2001 also requires schools to consult with parents when they are developing or reviewing their sex education programmes. It states:

> *"Parents play a key role in all aspects of their children's education. It is good practice for all schools to inform and consult parents and carers about key aspects of the curriculum. This is particularly important in relation to sensitive and potentially controversial areas such as sex education. All schools should adopt the practice of consulting parents and carers when they are developing or reviewing their programme of sex education. All parents and carers should be given the opportunity in advance to view key teaching materials and to ask questions about any aspect of a sex education programme. Schools should also give pupils an opportunity to identify and express their own needs."* (Circular 2/2001, Para 11)

58. Since the publication of Circular 2/2001 there continued to be public debate around the content of SRE in Scotland and concerns expressed as to the extent to which the Circular was being implemented in practice. In 2002 the Education, Culture and Sport Committee of the Scottish Parliament considered an 11,500 strong petition expressing concern about some materials included in a resource list produced by Learning & Teaching Scotland in 2000 in its publication 5-14 Health Education – Guide for Teachers and Managers. The Committee concluded that there were grounds for concern over some of the materials and their compatibility with Circular 2/2001 and obtained a commitment from Learning & Teaching Scotland that the guidance document would be reviewed.

59. It is evident that SRE is a controversial and politically sensitive subject in Scottish society. Within the highly polarised debate over what is and is not appropriate to be taught in SRE in recent years there has been little consensus. The Scottish Executive has sought, however, to bring those from different ideological viewpoints together and to identify if a consensus is achievable. The development of approaches based on such a consensus is necessary for any initiatives to be successful in improving Scotland's poor sexual health record. The report of the Working Group on Sex Education in Scottish Schools and Circular 2/2001 reflect, as far as may be achieved, a consensus approach and the legal framework within which SRE should be taught.

60. Concerns remain as to the extent to which these documents are being implemented in practice. In particular, there have been specific concerns expressed over the compatibility of some resources with the overall approach laid down in Circular 2/2001. The extent to which the emphasis in Circular 2/2001 including the law on sexual behaviour, parental responsibility, family stability, commitment in relationships, self-restraint, respect for the views of others and the physical, emotional and moral implications and risks of certain types of behaviour, features in Scottish SRE programs is not clear.

Additionally, the extent to which schools are actively engaging in consultation with parents and carers and to which education authorities are fulfilling their obligations in this area is questionable.

61. More research is needed to identify the extent to which the McCabe Report and Circular 2/2001 are being implemented in practice. The importance of openness, accountability and a consensus–based approach in relation to the teaching of SRE cannot be underestimated if there is to be trust between parents, schools and education authorities. There should be a full review of the implementation of these documents in order to ensure that resources being used and approaches being adopted in the conduct of SRE in Scottish schools are in line with the legal framework outlined above.

62. Health boards and education authorities co-operate in the area of sexual health and this co-operation is likely to increase with development of Community Planning and Community Health Partnerships. However, health boards do not appear to be bound by the framework outlined in the McCabe Report and Circular 2/2001 in their provision of sexual health services to young people. Having said that, some health boards are seeking, as best practice, to consult with parents and carers regarding the content of sexual health programmes. For example, in October 2003 Healthy Respect published a consultation on parent and carer involvement in sexual health and relationship education (Powers, 2003). However, the extent to which this document complies with the framework laid out by the McCabe Report and Circular 2/2001 is open to question. It is important, therefore, that any review of the implementation of the McCabe Report and Circular 2/2001 should also include the extent to which health boards are required to work within the legal framework contained in these documents. If necessary the legal framework outlined above should be fully extended to health boards in their work within the school context and broader youth settings.

1.5.4. Enhancing Sexual Wellbeing in Scotland: A Sexual Health and Relationships Strategy (2003)

63. In November 2003 the Scottish Executive published for consultation the report of the Expert Group on Sexual Health. This group had been given a remit to draft a national sexual health strategy and the consultation document is an attempt to do so. Three broad aims for the strategy were drawn out:

- *To influence the cultural and social factors that impact on sexual health.*
- *To support everyone in Scotland to acquire and maintain the knowledge, skills and values necessary for sexual wellbeing; and*
- *To improve the quality, range, consistency, accessibility and integration of sexual health services.*

64. The ideological basis of the draft strategy is a ‘rights-based’ approach that focuses on the right of young people to safe and healthy sexual relationships and the ability to access the services and the information they need to fulfil these rights. Within this framework the report has sought to address Scotland’s current sexual health problems, by recommending enhanced provision of sexual health services and the promotion of a broad understanding of sexual health that includes relationships, emotions, attitudes and social contexts. The recommendations from the draft report can be summarised under the following four broad headings:

A Broad and Holistic Approach to Sexual Health

65. The draft strategy suggests that in seeking to address poor sexual health there should be recognition of the need to utilise more than health care services. It argues that there are much broader factors behind improving sexual health including the need to address increasing educational aspirations, self esteem, enhancing social inclusion and facing alcohol and drug misuse. The draft sexual health strategy retains the targets for reducing teenage pregnancy by 20% by 2010, but claims to seek a broad holistic approach to meeting these targets.

The Media and Mass Communication

66. The influence of the media on young people is acknowledged with sexual imagery pervading much of our media input and being used to sell many goods. The draft sexual health strategy acknowledges that the portrayal of sex and relationships in the media sometimes reinforces stereotypes and ignores risks

associated with sexual behaviour. The need to bring balance to these messages is acknowledged in the strategy. Three broad aims are proposed: (1) Campaigns to use the media in promoting positive sexual health messages; (2) Advocacy work to influence the media in portrayals of sexual relationships that are positive; (3) Literacy work to help people to interpret and analyse media messages. Media work will have a focus on promoting barrier contraception along with other forms of contraception in order to protect against STIs and unintended pregnancy.

Promoting Positive Sexual Health

67. The draft strategy identifies a number of perceived barriers to sexual health, including the lack of empowerment of the individual in their choice regarding sexual relationships, physical barriers to using sexual health services and social and cultural barriers to using services. It recommends a variety of measures aimed at reducing and/or eliminating these perceived barriers. The draft strategy also highlights some of the barriers perceived by parents in communicating with their children on matters of sex and relationships. These include lack of awareness of the need for sex education, embarrassment, uncertainty regarding how to teach their children and what is happening in schools. They also lack accurate knowledge and feel a lack of skills to be able to communicate about sexual health.

68. Inconsistency in approaches to SRE across Scotland is seen as one such barrier. It is argued that parental involvement in SRE is vital and the full implementation of the McCabe Report is recommended. The Strategy also recommends a consistent approach to SRE across Scotland and the piloting of the Healthy Respect curriculum framework, currently used in only a few schools, to be used across Lothian to see if it can be used as a model for school-based SRE throughout Scotland.

69. Closer links between school sex education and clinical services is also recommended in the draft strategy. It is argued that SRE should link in with clinics offering information, counselling and sexual health services. It is suggested that these services be located near to, or even in some cases, within schools. All this should be in consultation with young people and their families.

70. The draft strategy encourages lifelong learning on sexual health matters. This would include raising awareness of sexual health among older people through workplace health promotion. Other suggested means to achieve this aim are work in higher education institutions, community education and youth work settings.

71. Enhancing sexual and reproductive health services and supporting clinical staff to develop their skills and services is the basis of a number of recommendations. The draft strategy argues that sexual health services should have better service information, improved access and increasing perceptions of confidentiality. It is suggested that contraception availability should increase, especially to high-risk groups, and measures taken to encourage the development of skills in the use of condoms. The report also recommends that the use of postal testing kits developed by Healthy Respect be rolled out across Scotland in an attempt to improve STI detection. As yet the success of this initiative is unproven and it is important that evidence is made available for the effectiveness and cost-effectiveness of this particular approach before it is used elsewhere.

Supporting Change

72. The draft strategy argues that there is a need for sexual health to become a priority in health care resource allocation. Further, that for change to be achieved, leadership is considered essential. It recommends that a National Sexual Health Coordinator and Sexual Health Advisory Committee be appointed to oversee progress on the Sexual health strategy and advise on its implementation. Local Sexual Health Coordinators are also recommended to oversee the implementation of any national strategy and the co-ordination of services in NHS Board areas. The draft strategy concludes that professional development and training to meet the growing sexual health needs is required. Additionally, there is need for ongoing research to test implementation of the proposed strategy and it recommends that NHS Health Scotland and the Sexual Health & Wellbeing Learning Network should continue to provide guidance on implementation of any national strategy.

Comment

73. There are many positive things to be said about the proposed sexual health strategy. Not least among these is the collaborative goal of improving sexual health and reducing the number of STIs and unwanted pregnancies. The emphasis on a holistic approach which acknowledges that sexual health cannot be influenced by health professionals alone, but by broader influences on young people, is a vital point to make. Work with the media is an encouraging development since it has a vital influence on youth culture. Parental involvement is also encouraged and it is recommended that the Scottish Executive fully implement the McCabe Report. The importance of parental involvement cannot be underestimated, and parent-child connectedness is a key underlying factor influencing sexual behaviour (see Chapter 2, Sections 2.4.1.-2.4.3). It is to be hoped that the Scottish Executive fully works through this recommendation to re-integrate parents into the role of educating their children about sex and helping to improve parent-child connectedness. In relation to work with young people it is important that there is full consultation with parents in line with the legal requirements set out for educational authorities in Circular 2/2001.

74. The suggested preventative measures do not, however, go far enough in seeking to improve sexual health in Scotland. A much broader preventative approach is needed. Great emphasis is placed on the provision of sexual health services but, whilst necessary, it does not help address the underlying problems leading to sexual ill health. Further, the strategy encourages the linking of such services to schools and sex education programs. As outlined when discussing SHARE (see Section 1.4.2), the evidence-base for the effectiveness of such measures is limited, with no reliable evidence that such approaches decrease teenage pregnancy or increase contraception use. Measures outlined, such as work with the media, parental involvement, work to prevent social exclusion, and SRE in school are vital and commendable. However, greater definition of what is proposed would be helpful. Media work could include the provision of information about positive reasons why someone may wish to delay sexual activity until they are older, or for example, helping young people understand how sex may be used to fulfil non-sexual needs (see Section 2.3.1). In relation to SRE, there needs to be greater emphasis on the benefits of delaying sexual activity as well as teaching skills to say 'no' (see Section 1.4.2).

75. SHARE is described in the draft sexual health strategy as an abstinence-plus program. Moreover, the draft strategy itself claims to be based on an abstinence-plus approach. However, SHARE has very little if any focus on abstinence (see Section 1.4.2). The evidence for the effectiveness of abstinence-based programs from the USA is growing (see Chapter 3, Section 3.3). There are already successful examples of abstinence-based programs that could be learned from and a distinctly Scottish abstinence-plus approach developed. Further, the draft Sexual health strategy highlights that: *'There is a broad consensus of most Scottish parents, teachers, professionals and leaders that sexual relationships are best delayed until a young person is sufficiently mature to participate in mutually respectful relationships…'* (Scottish Executive, 2003). The over-riding emphasis, however, in the proposed sexual health strategy (and also SHARE and Healthy Respect) remains easier access of contraception with the benefits of delaying the onset of sexual activity being a secondary consideration. The draft Sexual Health Strategy does not focus on how an abstinence-plus approach should be worked out. Proposed approaches at present shy away from explicitly encouraging delay in sexual activity, perhaps out of fear of being paternalistic and imposing morality or because of a lack of political support. Encouraging delay does not however have to be like this. It simply provides the information that delaying the onset of sexual relationships until young people are older is in their 'best interest', and leaves the decision to the young person. It also involves providing the skills necessary to follow through with this decision (see Chapter 4, Section 4.3.3.). As such, in its present form the draft Sexual Health Strategy is unlikely to deliver the improvements in combating the spread of STIs and reducing teenage pregnancies.

1.6 Conclusion

76. This chapter has outlined the extent of Scotland's current sexual health problems. It has detailed that the UK has the highest rate of teenage pregnancy in western Europe, with a peak in Scotland of 59.1 per 1000 in Dundee. It has also shown that there have been steadily rising levels of STIs over a number of years. In Scotland Chlamydia cases in particular are reaching epidemic proportions, with diagnoses increasing by

38.2% between 2000 and 2002. HIV rates continue to rise, although still comparatively small by international standards, with increasing instances of heterosexual transmission. There were also significant increases in reported cases of other STIs such as Gonorrhoea, Syphilis and Genital Warts.

77. This chapter has also detailed the results of the NATSAL study which shows high levels of demand among both men and women for information on STIs and relationships with a lower, but still substantial level of demand for information on contraception. Additionally, the NATSAL study shows that the average age for first intercourse among Scots is 16 with only 53% of men and 41.6% of women being judged competent at first intercourse. Substantial numbers of young people experience regret over their first experience of sexual intercourse and this is particularly pronounced for women. Peer pressure and alcohol are shown to be factors that can lead to first intercourse and it is likely that these factors will need to be addressed by any successful initiative to improve Scotland's sexual health record. A significant minority of Scots are engaging in high-risk sexual behaviour, such as maintaining concurrent partnerships and engaging in unsafe sex.

78. Over recent years, there have been a number of initiatives aimed at improving Scotland's sexual health record. The two most significant of these are the Healthy Respect demonstration project in Lothian and the development of the SHARE programme by HEBS. The jury is still out on the effectiveness of the Healthy Respect project in improving sexual health and in reducing unwanted teenage pregnancies. Although evidence from the Lothians shows that rates of teenage pregnancy and STIs have increased since Healthy Respect was launched in 1999, it is still too early to make a definitive assessment of the success or failure of the project. The project was slow in getting started and some of the increases in STI rates may be due to increased reporting arising from the Healthy Respect initiative. Similarly although a control study of SHARE showed little success in changing behaviour, and in particular in increasing condom usage, SHARE did, however, lead to a reduction in feelings of regret. Additionally, the programme might benefit by giving priority to providing reasons why young people might wish to delay the onset of sexual activity, whilst still providing information about contraception. This might improve its effectiveness in changing behaviour as is evidenced by experience from the USA (see Chapter 3, Section 3.3.)

79. Since 1999 there have been a number of significant developments in the wider policy framework within which SRE should be set in Scotland. Not least among these are the requirements placed on local authorities to *'have regard'* for guidance issued by the Scottish Executive and to ensure that SRE be appropriate to the age and understanding of the child concerned. The McCabe Report and Circular 2/2001 lay out the importance of involving, and consulting with, parents in relation to curriculum development and the importance of presenting SRE within the context of *'sound values'*. It is the contention of this report that in order for any programme of SRE to be successful it must, as far as possible, find a consensus approach to this highly charged political issue. To a large degree the McCabe Report and Circular 2/2001 represent such a consensus. However, it is evident that concerns remain as to the extent to which these documents are being implemented in practice by education authorities and health boards. These documents should be reviewed in order to ensure their full implementation by education authorities. Additionally, the legal framework created by them for SRE should be extended to health boards in relation to all sexual health education relating to young people.

80. The Scottish Executive's draft Sexual Health Strategy seeks to include both the 'harm reduction' and 'rights based' approach of Healthy Respect and SHARE, combined with the emphasis upon parental involvement and relationships contained in the McCabe Report and Circular 2/2001. It also recognises the wider social, cultural and economic influences upon sexual behaviour. It calls for better co-ordination of, and access to, sexual health services and, among other recommendations, the full implementation of the McCabe Report. Its emphasis upon work with the media to get a consistent message across in relation to sexual health, parental involvement and the wider social context of high rates of teenage pregnancy and poor sexual health are to be welcomed. However, despite being described as an 'abstinence-plus' programme the draft strategy fails to adequately address the benefits of encouraging delay in the onset of sexual activity. This applies both in relation to its proposed media campaign and school based initiatives. This is despite the draft sexual health strategy highlighting the consensus among parents, teachers and others that delay in sexual activity is in the young person's best interest until they are older. There is a great emphasis on harm minimisation through easier access to contraceptive services and the linking of

these services to school sex education programs. However, there is an alarming lack of reliable evidence for the effectiveness of such approaches in reducing teenage pregnancy or increasing condom use significantly. The final strategy should be more explicit in encouraging delay, not to moralise, but in order to give young people all the facts and empower them to make their own informed choices.

Chapter 2
Initiation of Teenage Sexual Activity

2.1 Introduction

81. The following chapter gives an overview of the major reasons why teenagers may initiate sexual activity. The aim of this section is not to be a comprehensive literature review, but an overview of the key issues that surround the debate on the initiation of sexual activity among young people. The current problems of unplanned teenage pregnancy and the rising incidence of sexually transmitted infection demand that the factors and motivations behind adolescent sexual activity and risk behaviour be reconsidered so that new approaches to sexual health promotion can be identified, and to consider if any major areas are currently being overlooked. In addition to the reasons identified by young people themselves e.g. sexual pleasure, libido (see Section 2.2) and peer pressures, there are a number of other factors which come under the following headings: *Psychological Factors* consider, among other things, risk behaviour, non-sexual needs and self-esteem; *Family System* looks at family background, parental monitoring, relationships and communication; and finally, *Extra-Familial System* considers socio-economic status, media and peer pressure. Unless these factors are understood and acknowledged, it will not be possible to really help young people understand the issues and empower them in their own decision-making.

2.2 Biological Factors

82. It is often presumed that teenage sexual activity is caused by hormone increases associated with puberty and a corresponding increase in the sex drive. Puberty marks the physical changes in adolescence, caused by shifting levels of hormones. In other words, puberty and hormones are distinct influences on young people although they are clearly related to one another.

83. Research into the effects of puberty and hormone levels on adolescent sexual activity has led to some established conclusions. For boys the change in hormone levels during puberty is stark. A boy can experience the change from pre-pubertal to adult hormone levels in a period as short as six months. The change is quick and potentially shocking (Udry, 1990). For girls, the change in hormone levels during puberty is a lot more gradual and tends to happen at an earlier age than for boys. One area of debate has been whether hormones alone are the catalyst for sexual activity among adolescents, or whether it is the social interpretation of the physical changes of puberty which acts as a signal within society of the progression into adulthood (Orr & Ingersoll 1995). For boys, the change in hormones such as Testosterone work directly to affect sexual initiation rather than being mediated through the effects of the physical changes of puberty and their interpretation in society. It is suggested that physical pubertal development has no discernable impact on the transition of males to sexual activity (Udry, 1990). However, for girls, hormones appear to have no independent impact on transition to sexual activity. The physical changes during puberty do however seem to have an impact, and this is through the social interpretation of these physical changes (i.e. breast bud development) (Udry, 1990).

84. We know that for both male and female teenagers, hormone changes affect the libido and sexual motivation; however, the actual working out of this sexual motivation seems to be determined much more by social controls among female than among male adolescents (Udry & Billy, 1987). Interestingly, Udry

and Billy go on to state that although the hormone changes in males are strongly correlated to the initiation of sexual activity (this is quite easy to measure because of the rapid increase in hormones among boys), social controls, nevertheless, do have an impact even if they are not discernable in the research. They conclude by suggesting that nothing in their analysis would contradict the possibility that boys were influenced by strong peer pressure to initiate sexual activity (Udry and Billy, 1987).

85. A further area of interest is the relationship between the timing of puberty relative to other peers and sexual initiation. Puberty is socially interpreted, and early puberty, relative to peers is often related to the increased likelihood of sexual debut (Kotchick, Shaffer, Forehand & Miller. 2001). Such adolescents may have more opportunity to associate with older peers who are involved in more risk taking activities such as sex. These peers may exert a greater pressure to conform to their peer group, and parental awareness of early puberty may potentially lead to a premature relaxation of rules and corresponding higher expectations for age appropriate behaviours, perhaps before adolescents are cognitively and socially mature enough (Orr and Ingersoll, 1995).

86. Due to the growing awareness that puberty is determined in its effect through social controls and the corresponding psychological development in the adolescent, Irwin and Millstein have suggested the broad biopsychosocial model of interpreting teenage sexual activity. Puberty, and its related increases in hormone levels provide the necessary precursor to any sexual activity in providing for the growing sense of sexual interest and drive. Puberty, has also been shown to affect multiple facets of the adolescents life including family interactions, parental and peer relationships, educational achievement, patterns of intimacy, and importantly in psychological self-conceptions of the adolescent, including body image and self-esteem (Irwin and Millstein, 1986).

87. There are therefore a multiplicity of social controls on hormone and puberty effects that need further investigation (Halpern, Udry & Suchindran, 1997). Chapin makes the important point that although hormone changes are a necessary precursor to sexual activity, they still do not explain why some individuals have multiple high-risk sexual relations whereas others do not. Indeed, study into the initiation of teenage sexual activity must look beyond libido for explanations as to why some teenagers have sex and others do not (Chapin, 2000).

2.3 Psychological Factors

2.3.1. Non-sexual needs

88. Adolescence is a period of great psychological, emotional and physical change. For many different societies it has been the transitional point from childhood into adulthood. According to Erikson's model of the '*Eight Stages of Man*', the major task of adolescence is the formation of identity (Erikson, 1965). Identity formation is the development of a consistent self-image that will depend on the adolescent's view of his or her mental and physical abilities and the responses that they gain about themselves from the environment and their social milieu (Cohen, 1995). Similarly, Hill suggested five life tasks that are important during adolescence: (1) Identity – discovering and understanding the self as an individual; (2) Intimacy – forming close relationships with others; (3) Autonomy – establishing a healthy sense of independence; (4) Sexuality – coming to terms with puberty and expressing sexual feelings; (5) Achievement – becoming a successful and competent member of society (Hill, 1983).

89. It is during this period of change that teenagers develop more complex social networks, and the reference point by which teenagers guide their behaviour can shift from the family towards the social environment. This may involve, to a certain degree, the rejection of parental values. The failure to gain a consistent self-image can lead to what Erikson called identity confusion or diffusion. A period of such confusion, in the midst of identity formation, would be common. However, it is thought that for some teenagers this period can be particularly intense and prolonged (Cohen, 1995).

90. It is in this context that the non-sexual motivation behind sexual behaviour can develop. Hajcak and Garwood (1988) proposed the idea of '*Quick-Fix sex*', they suggest that the intensity of the adolescent sex

drive is due to more than just libido. They state: *'…adolescent sexuality is largely driven by emotional needs that have little or nothing to do with sex. Adolescents have sex when, in fact, they primarily want or need something else, such as affection, to ease loneliness, to confirm masculinity or femininity, to bolster self-esteem, to express anger or escape and satisfy nonsexual needs'* (Hajcak and Garwood, 1988). They go on to suggest that the fusion of these non-sexual needs and the sex drive can lead to hyper-sexuality, because these needs all compete for satisfaction, therefore inflating the sex drive. First, what can happen is that adolescents' sexual needs are never completely satisfied, and the drive for sex remains high. Secondly, the non-sexual needs (affection, desire to be loved…) are often unmet through sexual activity and the needs remain high. These needs therefore become fused and the force of the sex drive may seem stronger. The fulfilment of these multiple needs is therefore seen to be through sexual activity only (Hajcak and Garwood, 1988). Such needs are rarely static, but may change depending on the stage of development the adolescent is moving through. Cohen suggests sex may be used to satisfy other non sexual needs for example, to gain peer approval as the adolescent builds a sense of identity independent of family and as a cry for help if the teenager has been abused in some form or lacked the affection or support from the home. Sex may also, in the extreme, be used as a form of rebellion and a desire for independence. Importantly it can be used to fulfil a desire for intimacy. For girls especially, sex is seen as being closely related to intimacy. There is often a presumption that sexual activity will provide the sense of emotional intimacy that they desire. Girls are often disappointed when such support is lacking. For boys the act of sex may not be seen as being related to emotional intimacy to the degree that it appears to be for girls (Cohen, 1995).

91. Using sex as a coping mechanism rarely leads to the resolution of conflict in the formation of identity, and can lead to psychological problems such as depression and other social consequences (Cohen, 1995). There are two areas where there needs to be further research related to non-sexual needs and the formation of identity in the adolescent. Firstly, the idea originally suggested by Erikson, that engagement, by the adolescent, in adult activity such as sex before identity is more secure, and a degree of emotional maturity is reached, may lead to identity foreclosure (a delay in identity formation). Secondly, the relationship between the use of sex to fulfil non-sexual needs, and the well documented incidence of regret among some sexually active adolescents (Wight, et al, 2000), is certainly correlated, and needs further consideration. It may be that in seeking to prevent such regret, young people are helped to understand the needs they have and how they may be seeking to fulfil these through sexual activity.

92. Cohen challenges those involved in sexual health to recognise that adolescent sexual behaviour reflects a variety of emotional needs and sociocultural pressure, in addition to the previously discussed sex drive. He suggests that effective primary intervention will only work when teenagers are helped to understand these motivational factors and strategies are created to help teenagers cope with these emotional and societal pressures (Cohen, 1995). Hajcak and Garwood suggest that one could help teenagers understand the needs that they are seeking to fulfil through sex, and find other ways of meeting these needs, thus leading to a greater self-understanding, an important part in the formation of a healthy sense of identity (Hajcak and Garwood, 1988).

2.3.2. Risk Behaviour

93. The relation between sexual activity and other risk taking behaviours is well established. Orr et al, emphasise that: '*The data suggests that early sexual experience among adolescents is associated with other potentially health-endangering behaviors and that the syndrome of problem behaviors is important to this age group*.' They go on to point out that adolescents who initiated sexual activity were more likely to start using drugs in the subsequent year and vice-versa. Also, with increasing age coitus is linked with a greater chance of alcohol and marijuana use (Orr et al, 1991). Kotchick et al., in their review of sexual risk behaviour found that it was associated with, among other things, delinquency and substance use (Kotchick et al, 2001). These findings are found throughout the literature on risk behaviour. Kotchick et al., further point out that research from the USA found that 24.7% of sexually active adolescents had used drugs or alcohol during their most recent sexual experience (Kotchick et al, 2001). Figures from the National Longitudinal Study of Sexual Attitudes and Lifestyles (NATSAL) study of Scotland show figures that are much lower with Alcohol use among 13-14 year-old males at 11.8% - one of the higher figures (MacDowall et al, 2002). Importantly, Orr et al. and Rosenthal et al. both emphasise the bi-directionality of these risk factors. In other words, initiating coitus does not **just** lead on to alcohol consumption; the

relationship works both ways (Orr et al, 1991; Rosenthal et al, 2001). Von Ranson et al, points out that for girls in their study '*being drunk or high was rarely a reason for having intercourse the first time. It is important to note that drinking at first intercourse is different from drinking as a reason why the adolescent had sexual intercourse. Alcohol and drugs may serve as a social cue for sexual activity rather than a cause for the decision to engage in sexual behaviors.*' (quoted in Rosenthal, et al, 2001).

94. Age has also been found to relate to risk behaviour. Kotchick et al, point out that the younger the person at the initiation of sexual activity the less condom use, the higher the rates of pregnancy compared to peers, and thus the increased risk of STIs (Kotchick et al, 2001). Mellanby et al, in a paper in the BMJ backed up this point by comparing those who had sex before 16 with those who had sex post-16. The former were twice as likely to have sex without the use of contraception, twice as likely to have had sex in the midst of a short-term relationship, and three times more likely to know a friend who has an STI (Mellanby et al., 1993).

95. Regarding gender differences, a review of risk behaviour by Kotchick et al, found that both genders appeared to be equally likely to engage in risk taking behaviours with a few slight differences. Adolescent boys tended to have more sexual partners, and girls were less likely to report consistent condom use with partners (Kotchick et al., 2001).

96. The relationship between adolescent knowledge of risk and risk behaviour has been well researched. The long presumed connection between increasing knowledge of risk and a reduction in risk behaviour has been thoroughly challenged. Again, Kotchick et al., in their review found 10 studies that directly addressed this issue, five studies found that more information about sexual risk and prevention helped reduce risk behaviour, four studies found no relation between information and sexual risk behaviour and one study found that more accurate knowledge of risk increased the level of sexual risk behaviour (this was among a sample of substance abusing youth). The relationship is therefore unclear. The mediation between increased knowledge of risk and reduced sexual risk taking has been suggested to be through greater moral reasoning amongst some adolescents, and the adolescents' perception that they themselves are at risk. However, such suggestions fall foul of methodological pitfalls, for example, an adolescent may perceive they are at risk, because they are actually sexually active! (Kotchick et al., 2001).

97. Many other factors are related to risk behaviour that, to some extent, are presented in the rest of this chapter. For example, young people living with both parents is a protective factor against high-risk sexual behaviour. Similarly, greater parental monitoring is related to lower sexual risk behaviour, (as long as it is not monitoring that is overbearing and coercive). An adolescent's perception of their peers' behaviour is also thought to relate to sexual risk behaviour (Kotchick et al., 2001). Kalmuss et al, suggest that the lower the socio-economic status, parental educational attainment, and the teenager's own educational attainment, the greater the sexual risk activity (Kalmuss et al., 2003).

2.3.3. Risk Behaviour and Cognitive Development

98. The discipline of developmental psychology offers some helpful insights into the reasons behind teenagers risk-taking behaviour. Cognitive development amongst adolescents is an important element. It is known, for example, that 13-year-olds are very different from 19-year-olds in their cognitive development. The age of 6 or 7-years-old has traditionally been seen as the 'age of reason' for children. However, it was Piaget (the developmental Psychologist) who, through his analysis of childhood cognitive development, came to believe that around the ages of 11 or 12, young people attain a new and higher order level of reasoning that takes them beyond earlier childhood thought (Elkind, 1984). This age has been disputed, and current suggestions are that by 16 around 70% of teenagers have reached the stage of cognitive development (Strasburger, 1989).

99. This transition is marked by a shift from what is called *concrete operational thinking* (COT) to *formal operational thinking* (FOT) (Biro and Rosenthal, 1992). The transition is normally characterised by a number of changes. For example, those who are concrete operational thinkers are unable to recognise behaviour that places them at risk, whereas those who have developed formal operational thinking would be able to use hypothetical reasoning that would allow them to begin to reason beyond their immediate experience.

The latter group would be able to hypothesize about the probability of risk that a certain behaviour (sexual activity) may incur. For those who are concrete operational thinkers they will be unable to potentially hypothesize in such a way (Biro and Rosenthal, 1992). Thinking shifts from concrete to formal which makes it more abstract, and less egocentric (thinking centred around the self) towards de-centred thinking (thinking not centred on the self). Teenagers develop the ability to plan ahead, understand the interplay of emotions and actions and appreciate risk and longer term consequences. The way the adolescent looks at the world and makes decisions is determined by these cognitive changes (Ingersoll and Orr, 1995). Ingersoll and Orr cite a number of studies that back up their hypothesis that adolescents operating at higher levels of thinking are less likely to be involved in risk activities, and are more likely to resist peer pressure because of their greater independence and greater internal locus of control (the belief in how far one believes their actions will determine their future). They state: "*The shift in conceptual level* (thinking becoming more complex to higher levels) *is associated with increasing ability to consider alternatives and to direct behaviour…More complex individuals demonstrate more empathy, more autonomy, more independent styles, better information processing, and less field dependence"* (Ingersoll and Orr, 1995). They go on to show that, using the protective measure of condom use among those who are sexually active the hypothesis was true for girls, those who were less cognitively complex were less likely to use condoms. However, for boys the situation was reversed (Ingersoll and Orr, 1995). Chapin suggests: *'It may be the case that the most extreme sexual risk-takers are those who achieve puberty early, but lack the cognitive capacity to make informed decisions (especially regarding the probability of negative outcomes). In addition their social contexts may be conducive to risky behaviours'* (Chapin, 2000).

100. Sue Stuart-Smith in an editorial for the BMJ suggested that cognitive immaturity had a lot to do with adolescent risk behaviour and suggested the incorporation of this and the wider body of the psychology of adolescence into the sexual health approaches (Stuart-Smith, 1996). A contradictory paper using a small sample has suggested that 14 year olds are as capable of making health decisions as adults, but 9 year-olds are less capable (Wiethorn and Campbell, 1982). Indeed this is a hotly contested area of debate that certainly needs more work. For some, the idea that many teenagers are deemed cognitively limited in their ability to negotiate condom use and make competent health choices is seen as patronising, denying them their right to make health choices and freedom to develop safe sexual relationships. For others, the failure to acknowledge the cognitive immaturity of many teenagers, their increased susceptibility to risk, the challenges of developing intimacy in these formative years, and the normal problems of messy first sexual experiences, suggest that we are expecting too much of teenagers and should encourage delay until they have more fixed identities and a degree of maturity. More research is certainly needed to establish the issues. The problem with cognitive development is that it is not strictly related to age. One 14 year old may be cognitively capable of making competent health choices, while another may not have developed formal operational thinking, thus making them more culpable to risky behaviour. The age of the transition from concrete operational thinking to formal operational thinking, suggested earlier to be between 11 or 12 years old, has been called into question. Formal operational thinking has been thought to solidify around 14 years of age. However this may be task dependent. Adolescents may be able to apply their FOT to their algebra problems but not to their sexual behaviour (Biro and Rosenthal, 1992). Cognitive development could thus be restricted to certain areas where the adolescent has personal experience, thus potentially leading to problems for adolescents initiating sexual activity as this will be a new area of experience where formal operation thinking may not yet have been applied (Gordon, 1990).

101. The dynamic between cognitive development and risk taking has been explained in terms of the unique forms of egocentrism and self-centred thinking that results from the transition from COT to FOT (Biro and Rosenthal, 1992).The aspects of this egocentrism that relate to risk are what have been called by David Elkind the *Personal Fable* and the *Imaginery Audience*. Elkind explains the terms: *'…teenagers who are preoccupied with what is happening to their bodies as a result of puberty and who are enthralled with their new thinking abilities begin to believe that everyone is thinking about what they are thinking about: namely, themselves. The belief that everyone, is thinking about them and is concerned with their actions and thoughts is what I have called the "imaginery audience". The imaginery audience is a powerful construction and has considerable influence over teenager's behavior. For example, it is the imaginery audience that helps explain the pervasive self-consciousness of the young teenager.'* Elkind continues, *'Another complementary structure with equally broad consequences for young people with health problems is called the personal fable. If everyone is watching you and thinking about you – thanks to the imaginery*

audience – then you must be something special, somebody unique and different. Other people will grow old and die, but not you! Other people will not realize their life ambitions, but you will, and so on. The fable, like the audience has value in that it enables us to carry on with our lives in the face of dangers of all kinds. It cloaks us in a kind of shield of invulnerability protecting us in all situations' (Elkind, 1984). One area where the personal fable is established in adolescent minds is through the media, where the portrayal of a non-monogamous relationships rarely, if ever, leads to sexually transmitted infection (Biro and Rosenthal, 1993).

102. Mellanby et al., in their paper in the BMJ bemoan the situation where, despite the knowledge of risk, and even when contraceptives are supplied in schools, the majority of young teenagers do not use them. (Mellanby, Phelps, Tripp, 1993). This has been suggested to be the result of the risk perception problem of younger more concrete operational thinkers. Importantly, the ability of teenagers to use condoms per-se has been brought into question by amongst others, Biro and Rosenthal, who suggest that it is easy to understand how adolescents focusing on their imaginery audience would have difficulty negotiating the use of condoms prior to sexual activity (Biro and Rosenthal, 1992). Elkind makes a similar point, suggesting that teenagers can fail to use condoms because of the personal fable which says: *'Other people will get pregnant, not me'* (Elkind, 1984). Research by Steinlauf has shown that the less able a woman is to take steps towards solving a problem the greater the chance of unplanned pregnancy (cited in Gordon, 1990). Gordon also suggests *' difficulty in evaluating the consequences of actions, as well as lack of planfullness in adolescent reasoning, have been cited by many authors as a major causative factor in the failure to use contraceptives. In fact, pregnancy was found to be "an unanticipated consequence" of sexual activity for many adolescent females, as well as males who did not use contraception'* (Gordon, 1990). In other words, they could not use hypothetical reasoning. Further, Cvetkovitch et al, has shown that among teenagers who become pregnant, most have difficulty assessing the probability of the risk of pregnancy from sexual intercourse. This problem has been likened to the 'gambler's fallacy', in that the probability of pregnancy is seen to be cumulative rather than independent for each episode of intercourse: *'I've only done it twice, I won't get pregnant!'* (cited in Gordon, 1990).

103. Cognitive development can be delayed among some adolescents. Delay may happen because of life crisis, such as parental divorce, abuse or pregnancy, all of which can disrupt the attainment of formal operational thinking in certain adolescents. One study suggested that stress and anxiety may inhibit the development of formal operational thinking (Gordon, 1990). The home environment or the general social environment, and whether it encourages reflective thinking and hypothetical reasoning, is also thought to affect and possibly delay cognitive development in the adolescent. More research is needed to establish the causes of delay in cognitive development and recognise those most at risk. Gordon also points out that possibly only 30% of a random sample of adults may display the complete acquisition of formal operational reasoning, thus indicating that many adolescents may be unable to reason formally in many areas of life (Gordon, 1990). In view of this problem of delayed cognitive development, it has been suggested that a way to encourage the attainment of formal operational thinking is to help teenagers to think hypothetically and reason about issues like sexual relationships. Sexual relationships are an area where formal operational thinking is unlikely to have been fully developed because of the teenagers lack of experience. The encouragement of such thinking could be undertaken through classroom discussion and debate (Gordon, 1990).

104. Of further interest, is the correlation that exists between cognitive complexity, the shift from concrete operational to formal operational thinking, intelligence and academic performance. Although they are different in their effects, poor academic performance is related to poor condom use, increased risk behaviour and pregnancy (Ingersoll and Orr, 1995 & Morrison, 1985).

2.3.4. Psychiatric Disorders.

105. There is growing evidence of a correlation between early sexual activity among teenagers and psychiatric disturbance. Ramrakha and colleagues have shown a correlation between substance misuse, risky sexual behaviour and psychiatric disorders in a birth cohort of 21 year-olds. They found that the strongest relation of risky sexual behaviour was with; '*disorders characterised by disinhibition or a pattern of impulsive behaviour (for example, antisocial personality, mania, and drug and alcohol dependence)'* (Ramrakha et

al., 2000). According to this research there was a connection between clinical depression and increased rates of risky sex, STIs and early sexual experience. Further, as Bennett & Bauman point out '*The causal relations and direction remain to be elucidated, but the coexistence of drugs, risky sex, and mental health problems remains a consistent observation in epidemiological studies'* (Bennett & Bauman, 2000). The connection between such psychiatric problems and sexual abuse, also a major cause of mental health problems, needs to be determined, but that there is a connection seems indisputable.

2.3.5. Sexual Abuse

106. The rates of sexual abuse are notoriously difficult to determine because for each case that is reported, many more are likely to have gone unreported. The perceived threat of the consequences of what may happen to the young person if they report may be a sufficient deterrent. Another reason for the difficulty in reporting is the differences in definition of sexual abuse. A broad definition would be as Putnam suggests: '*…intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography'* (Putnam, 2003). Estimates are that between 5% and 20% of women and 2% to 7% of men have been sexually abused. Of all the calls that Childline receive, 8% of these are about sexual abuse, and the majority of these calls are from children between 10 and 15 years old (www.childline.org.uk). Other studies suggest figures much higher than these, for example Rosenthal et al., found that between 15% and 44% of adolescents experienced some form of unwanted sexual activity (Rosenthal et al., 2001). Figures from the USA have suggested rates ranging from 15% - 26% to 43% - 62%. It is thought that girls have 2.5 to 3 times greater risk of suffering sexual abuse than boys.

107. An expression of a lack of willingness to have sex, may be used as a proxy measure for sexual coercion. An article in the BMJ, found that for young teenagers only 77% of boys and 53% of girls were as equally willing as their partner at first intercourse (Dickson et al., 1998). Women are much more likely to experience sexual coercion and possible abuse. As Wellings et al., show in a paper in The Lancet: '*Women are twice as likely as men to regret their first experiences of intercourse and three times as likely to report being the less willing partner'* (Wellings et al, 2001). The earlier the initiation of sexual activity in a woman the greater the likelihood that she had experienced involuntary or forced sex. In a study from The Alan Guttmacher Institute in the USA, 74% of female adolescents who had sex before the age of 14 reported that it was involuntary (American Academy of Pediatrics, 2001).

108. The correlation between a young person experiencing sexual abuse and subsequent risk taking sexual behaviour is becoming clear. Sexual abuse has been linked to a number of outcomes of high-risk sexual behaviours including teenage pregnancy (Kotchick et al., 2001). From adolescent women who experienced at least one incident of contact sexual abuse, Wyatt found that, in a particular sample, these women had intercourse on average 15 months earlier than women who were not sexually abused. Wyatt also found that necking and petting started earlier among abused women and that they were on average likely to have more sexual partners between 13 and 17 years of age, and relationships were of shorter duration (Wyatt, 1990). Fiscella et al, in a paper called '*Does child abuse predict adolescent pregnancy*' found that the mean age of first intercourse was 14.9 years for those who had suffered sexual abuse and 15.6 years in the non-abused group (Fiscella et al., 1998). Another study found that those who had suffered abuse were twice as likely to have had intercourse by the age of 15 (Stock et al., 1997). The correlation between sexual abuse and high-risk sexual activity is probably explained, to some degree, by the presence of psychiatric conditions related to child sexual abuse including; depression, borderline personality disorders, substance abuse, post-traumatic distress disorder, dissociative identity disorder, and bulimia nervosa (Putnam, 2003). The young person can experience a great deal of traumatic effects as a result of sexual abuse including a deep sense of betrayal from those who were previously trusted, feelings of worthlessness, powerlessness and a traumatized sexual development. This can sometimes lead to the extremes of promiscuity or frigidity. As to the relationship between such effects and risky sexual activity, Arata suggests that, of a sample of 221 women, those women who experienced '*…repeated victimization engaged in more self-blame, reported higher levels of post-traumatic symptoms, and reported more high-risk sexual behaviour. A path model was developed that indicated that the relationship between re-victimization and child sexual abuse was mediated by self-blame, post-traumatic symptoms, and consensual sexual activity'* (Arata, 2000).

109. The correlation of child sexual abuse and subsequent risky sexual activity seems quite clear. Although levels of abuse are difficult to determine, it seems that it may be a major problem in society. Indeed, it is possible that a large proportion of those who are most at risk sexually may also be sexual abuse victims. Thus, if such activity is to be reduced there needs to be a more concerted effort at seeking to prevent abuse, exposing abuse that is happening, and helping those who tragically have been victims. Two important issues are raised regarding sexual abuse. Firstly, the issue of coercion in sexual relationships and sex role socialization where 'boys will be boys' and girls can be seen as conquests and coercion is deemed acceptable. The step from coercion towards rape or sexual abuse can be a small one. Coercion denies the autonomy and rights of the individual, hence the need to address sex role socialization and coercion. Secondly, the use of coercion as an abuse of power in sexual relationships raises the question of ethics in sexual relationships that will be discussed later in Chapter 4.

2.3.6. Self Esteem

110. Self Esteem could be defined as the global ideas and attitudes people have about themselves. It can include: (1) Self-image - physical or public appearance; (2) Self-concept - how people view their personality, skills, competence and how comfortable someone may be with a task and whether they can make a meaningful contribution; (3) Self-worth - whether a person values themselves or feels significant (Hashem, 1985).

111. As outlined in Section 2.3.1., adolescence is a period of identity formation involving the development of a consistent self-image in line with physical and mental capabilities. As such, adolescence involves, to some degree, an identity crisis as the young person discovers more of who they are and how they will treat themselves. For some adolescents, this confusion may last for a short transitory period, for others, it is delayed, what Erikson called *identity confusion* or *diffusion* (Erikson, 1965). Thus, self-esteem is a very pertinent issue for many young people. It may be that many, if not most, struggle with how they value themselves, at least for a short time. It is difficult to pin self-esteem down quantitatively, for in many ways the other sections in this chapter talk about self-esteem in its broad definition. For example, teenagers seeking to fulfil unmet needs through sexual activity can be intricately linked to the young persons self-concept, value or image. Risk taking behaviour can be affected by how a young person views themselves. Psychiatric disorder and sexual abuse invariably affect self-esteem. The family system, for example family background and parental-child relationship, can also have a large effect on how young people may view themselves. Of further importance is the relationship between self-esteem and socio-economic status. Many teenagers are stuck in poverty, experiencing general social exclusion, and an environment that could generally be described as lacking self-esteem. Young people in these situations can feel isolated and lack the aspiration to better themselves.

112. Under the umbrella of self-esteem come terms like *self-efficacy*, which is an approach borrowed from social psychology, commonly used in sex education, which seeks to build confidence in the young persons ability to make decisions regarding, for example, the use of condoms or saying 'no' to pressure to have sex. This involves the imparting of the necessary skills, helping young people to plan ahead and build intentions regarding how they will act when faced with such situations. Self-esteem would also be closely connected to terms like the teenager's *locus of control*, defined as how far a person believes their actions will determine their future. The greater the sense of having control over one's life, the greater the internal locus of control. How a teenager views themselves is therefore crucial. Many young people have little confidence in themselves, and consequently have few goals for their lives. For many young people all they will hear about themselves will be negative comments either from friends or parents, or both, which can leave them wondering what value they have. Many do not believe in themselves and see little potential or hope for their lives. Teenagers desperately need help to believe and value themselves and to build goals into their lives.

113. An important recent paper highlighted the lack of evidence for a direct link between global measures of self-esteem and risk behaviours. It was found, for example, that young people who performed badly at school were more likely to be involved in sexual risk activity. However, when looking at other measures of self-esteem it was clear that these young people were not any lower than young people who did better and were more connected to school. In other words, on the surface certain measures of self-esteem were not

significantly related to sexual risk behaviour (West and Sweeting, 1997). What seems apparent is that the key factor in the link between self-esteem and risk behaviour, is influenced by young peoples' various strategies to gain self-worth and value, especially from peers. The paper found that young people who engaged in a 'street-orientated' culture were more likely to be involved in sexual risk. Such young people were disconnected from schools and yet showed normal self-esteem levels. Young people who are connected to school probably gain a great deal of the self-esteem from educational performance, for other children, their esteem may come more from their peer acceptance and image of this 'street culture'. The key factors in the relationships between self-esteem and sexual risk behaviour therefore appear to be connectedness to school and education, and the extent to which a young person gains self-esteem from the 'street' (West and Sweeting, 1997). Self-esteem seems to be a key underlying factor. However, it is the strategies that are employed to meet self-esteem needs that determine behaviour. Peers, and the extent to which a young person seeks to be accepted and popular, will provide a sense of self-worth and esteem but is nevertheless more likely, among certain peer groups, to be correlated to greater sexual risk behaviour.

114. A number of issues, therefore, come from these findings. Peer acceptance remains important (see Section 2.5.1) but may be reduced through changes in some of the following areas. Increasing the connectedness of young people to school is a vital factor on the influence of peer pressure and risk activities. Promoting career aspirations is likely to either delay sexual activity, decrease pregnancy or increase condom use (Kirby, Feb 2002). The influence of peer pressure can also be greatly determined by the influence of the family on the young person (see Section 2.4.3.). As can be seen from later sections on the family, close family connectedness, healthy communication, and a generally positive environment for the young person could greatly affect self-esteem and the likelihood of engagement in sexual risk behaviour.

2.4. The Family System

115. The family has seen large changes in its structure over the last century. We have seen a shift from the multigenerational family towards the nuclear or single-parent family (Cohen, 1995). No longer do children necessarily know their extended family of uncles, aunts and cousins and they may even not know their grandparents or their natural parents. This change inevitably affects adolescents, as they go through their development stages in the context of the family. The sections below 2.4.1.-2.4.3. seek to outline, in summary, some of the effects that family can have on young people and to discern a correlation between these changes and the possible initiation of sexual activity.

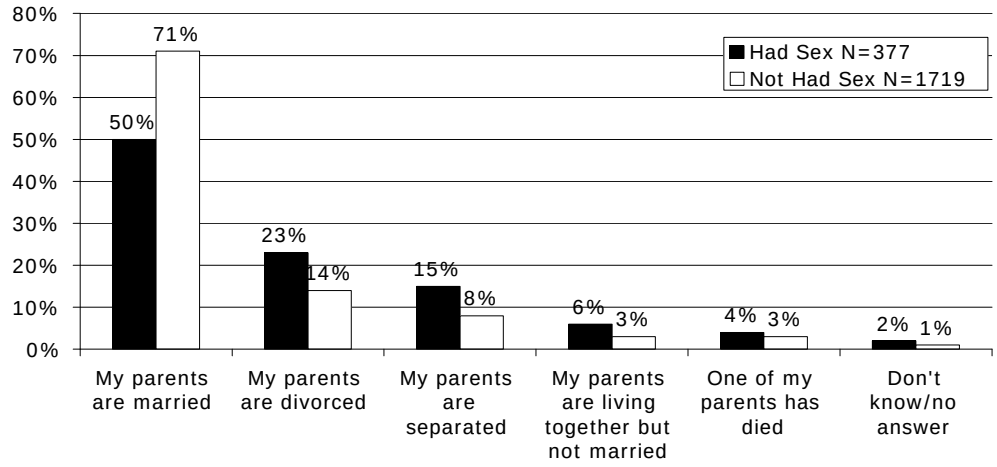
2.4.1. Family Background

116. Parents arguably are the most important influence on the sexual development of a child. Throughout the literature there is a clear correlation between family background and sexual activity. There is strong evidence to suggest that living with one's parents is protective against early sexual activity. Evidence shows that living with one parent serves a protective role but living with two makes a further difference in protecting the adolescent against engaging in further risky sexual behaviour (Kotchick et al, 2001). In another study, teenage males living with both parents were less likely to have sex and were generally older at first intercourse (Cohen, 1995). Papers from the UK also demonstrate this pattern. A study conducted by the Medical Research Council showed that the most important baseline factors that influenced sexual experience at age 16 were family composition and parental monitoring (Wight et al, 2002).

117. The following graph (Hill and Boydell, 2001) from a sample of 2250 pupils aged between 13 and 15 years old in England shows the relationships between family composition and sexual activity.

Graph 2

'Have you had sex yet?' A graph showing the response by family type



118. Of those who had had sex 56% were from homes with both parents i.e. either their parents were married or cohabiting. This is compared to 74% of those who had not had sex being from homes with both parents.

119. So what are the causes of these differences in sexual activity between households of various family compositions? It is suggested that family disruption due to parental divorce is a significant predictor of sexual risk for females in later adolescence (Kotchick et al, 2001). The break-up of a family is often characterised by the preoccupation of parents with marital problems, and the removal of one parent from the household, all contributing to the disruption and emotional turmoil that the young person will experience (Newcomer and Udry, 1987). The authors go on to suggest that increased sexual risk behaviour among girls and boys is correlated with the rapid increase in the loss of fathers from households in the US in the 1960s and 1970s. However, they also suggest that: '*For boys the loss of control is associated with the disruption inherent in the loss of the father from the household, while for girls the loss of control is associated with the state of not having a father in the household and not with the disruption per-se.*' (Newcomer and Udry, 1987)

120. Parents act as models of behaviour for their children. Women who grow up in single-parent households are more likely to become pregnant. One factor in this may be that they followed the dating and coital behaviour of their mother, and that such modelling potentially has more of an impact than any verbal information that may be conveyed. (Wyatt, 1990). '*The role model effect may overwhelm their* [the parents] *attempts to control their children's sexual behaviour. The effect might be expected to be more important for daughters than for sons.*' (Newcomer S & Udry J R, 1987).

121. Significantly, single-parent households are associated with greater poverty (Newcomer and Udry, 1987). Thus, single-parent households are more likely to be at a socio-economic disadvantage, which is correlated to lower aspirations and lower educational attainment. In addition, there is less likelihood of the parent modelling educational attainment to their children. The mothers in single-parent households are more likely to have to work full-time and are therefore less likely to be able to monitor their children's behaviour. Single parents are also less likely to be able to give as much time to communication and general supervision of their children compared with two-parent households. There are a number of studies that relate initiation of sexual activity to parental control behaviour, and parent-child communication (Udry and Billy, 1987). The presence of two parents can provide greater levels of control and supervision over their children. This issue will be looked at more carefully in section 2.4.3.

122. Overall, it is important to emphasise that the purpose here is not to undermine the fine efforts of single parents, but simply to point out what is a fairly established correlation between family structure and the initiation of early sexual activity. Other factors are: the disruption of divorce or separation and the

emotional consequences of these; lower socio-economic status of single-parent families or the fact that the mother has to work and is therefore, on average, less able to supervise their children. The issue of supervision and communication between parents and children, and the potential differences in values between parents will be looked at in more depth in sections 2.4.2. & 2.4.3.

2.4.2 Parental Values

123. Values underpin behaviour so it is vital to get an overview of how values are transmitted to young people both through direct communication and through the modelling of behaviour. Kotchick et al., has found that among a sample of pregnant teenagers stronger commitments to "conventional" values was related to lower levels of sexual risk behaviour (Kotchick et al, 2001).

124. The means through which values are communicated to young people include modelling of behaviour by the parent. Social learning theory and social cognitive theory suggest that learning occurs through observations, personal experiences, witnessing the experiences of others and interacting with the social and physical environment. As a young person interacts with the environment, they begin to interpret what the consequences of an action may be. Gradually moral standards become internalized in the individual through the process of self-observation and the reinforcement of standards by other people (Blake et al., 2001). It is suggested that parents who exhibit unsafe behaviours are especially likely to have children who are prone to unsafe behaviours. It is also suggested that risk is "*reproduced*" across generations, and that a mother who had sex at an early age is more likely to have daughters who become sexually active before the age of 14 (Wilder et al., 2002). Udry and Billy (1987) found from their research that for girls, their mother's education and adolescent sex behaviour, were significant. The attitude of mothers who gave birth as teenagers is also thought to be related to sexual behaviour in their daughters. For example, if a mother is open and accepting of having given birth as a teenager she is likely to encourage sexual activity compared with a mother who regrets giving birth as a teenager and who does not want their child to follow a similar path. She is likely to encourage delay in the initiation of sexual activity in her daughter. This may simply be communicated as parental disapproval of teenage sexual activity (Forste & Haas, 2002).

125. Similarly, it is suggested that modelling works indirectly through the perceived parental disapproval of sexual behaviour. In other words, nothing needs to be said specifically, rather it is the modelling of behaviour and the perception that parents would disapprove of sexual activity that has an influence (Kotchick et al, 2001). Parents have been rated highly in terms of influencing a teenager's attitudes and beliefs about sexual relationships, but they are less effective than friends, school and books as a source of sexual information (White and DeBlassie, 1992). Clearly, parents communicate values to children through one means or another. Parental communication with children is more fully outlined in section 2.4.3. Greater parental communication with children is correlated with lower sexual activity in their children. However, it is thought that this is only for girls of parents with traditional family values. In other words, communication from parents who would not necessarily discourage sexual activity in their teenage children, would be less likely to have an effect in reducing sexual risk behaviour (White & DeBlassie, 1992).

126. A new poll from the National Campaign to Prevent Teenage Pregnancy in the USA showed that the individuals most likely to influence a young person's decision to have sex were parents. They were cited by 45% of young people. Second were friends at 31%. It is interesting to note that only 32% of parents believed that they were the greatest influence on their children, with 48% of parents saying that they believed that friends were the most influential. Parents clearly underestimate their influence. When it came to healthy responsible relationships, 59% of teenagers said their parents were their models for behaviour (The National Campaign to Prevent Teen Pregnancy, 2004).

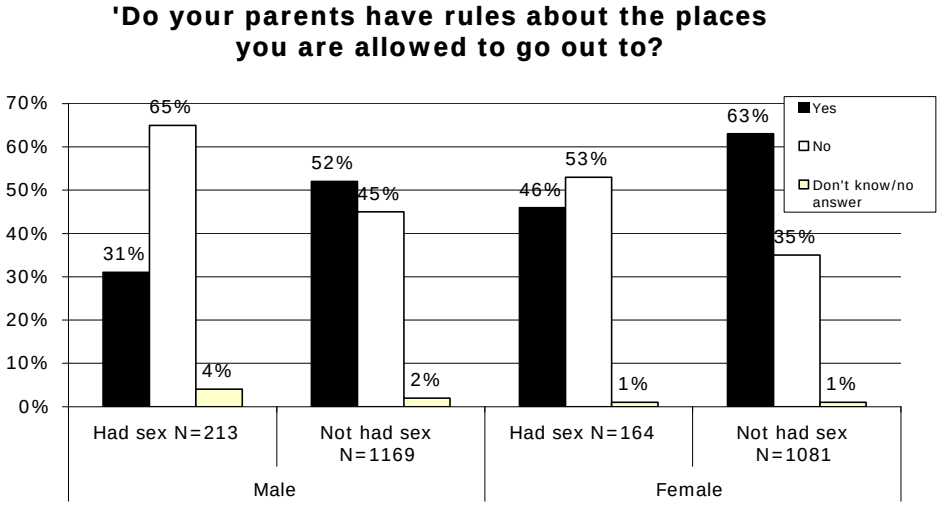
2.4.3 Parental Monitoring and Communication

127. Parents transmit their own values and standards to their children. This can be through modelling behaviour and values (as shown above), or through more direct communication including parental monitoring of

behaviour and the quality of the relationships and communication between the parent and child (Kotchick et al, 2001).

128. Among adolescents greater parental monitoring has been correlated with less sexual activity. Correspondingly, other studies have found a correlation between lower levels of monitoring and a greater number of sexual partners and inconsistent use of contraception (Kotchick et al, 2001). The following graph illustrates the answer to the question asked of 2250 children aged 13–15 years: '*Do your parents have rules about the places you are allowed to go out to?*' (Hill and Boydell, 2001).

Graph 3



129. The graphs illustrate a simple relationship between greater monitoring and those who have not had sex. Furthermore, it can be seen that girls are more likely to be monitored and have rules than boys. Elsewhere, research has demonstrated that supervision of girls who date has delayed the initiation of sexual activity (Wilder et al., 2002). Indeed, because girls bear the brunt of the possible consequences of sexual activity, they tend to have more of the focus of parental monitoring than boys. An important correction, however, is that although parental monitoring is related to lower sexual activity, this relationship does not work for either very strict parental discipline, or having too many rules (White & DeBlassie, 1992). Another study has shown that parents who have a psychological control that denies the adolescent autonomy is associated with a greater likelihood of sexual activity (Kotchick et al, 2001). Coercive parental control and excessive maternal intrusiveness is related to greater sexual risk activity in other studies (Miller, 2002). One of the possible reasons for this relationship maybe that the parent suspects that the young person is sexually active and therefore increases monitoring, perhaps in a coercive manner (Miller, 2002).

130. Rosenthal points out that parental monitoring, in its less controlling manifestation, is probably reflected in good parent-adolescent communication and relationships rather than surveillance and control (Rosenthal, 2001). Indeed, the quality of parent-adolescent relationships is a key mediating factor in monitoring which seems to prevent the initiation of sexual activity and risk behaviour. According to one review of studies, the greater the parent-child closeness, the lesser the chance of adolescent pregnancy. This is because of delay in sexual activity, fewer sexual partners, or using contraception more consistently (Miller, 2002). Hart has suggested that the less close a girl feels to her father the greater the likelihood of risk activity, including drug and alcohol use and risky sexual behaviour (Hart, 2001).

131. The quality of the relationship between a parent and child could be marked by the perception of support the teenager has. For example, whether the teenager perceives their parents as being supportive has been found to relate to sexual risk activity; with adolescents who perceive a lack of support being more likely to be sexually active and at higher risk (multiple partners and inconsistent condom use). Other research has suggested that part of this relationship is mediated by specific talk about sexual risk between parents and

children (Kotchick et al, 2001). Sex talk between parents and children in the context of non-coercive and supportive relationship is certainly important. The following graph illustrates the answer to the question '*Do you feel able to discuss very personal topics with your mother/father?*' asked of 2250 children aged between 13-15 years-old in England. The table shows a summary of questions regarding the quality of the relationship between teenagers and their fathers, comparing those who have had sex with those who have not (Hill and Boydell, 2001).

Graph 4

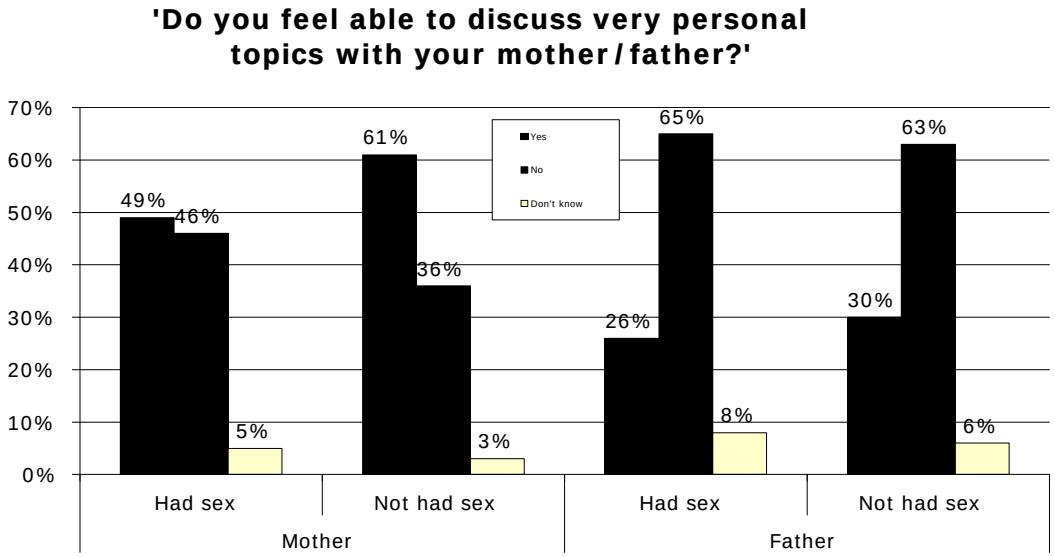


Table 1
Relationships between Teenagers and their Fathers

	Get on Well	Feel Close	Can talk freely
Had sex	69%	60%	37%
Have not had sex	82%	75%	45%

132. The graph and table illustrates that communication is much better between teenagers and mothers than is the case with fathers. Also, that communication between teenagers who have had sex and mothers was 49% compared with 61% who had not had sex. Similar figures for talking about personal topics with their father are much lower, but are 26% for those who had sex compared with 30% for those who had not had sex. Table 1 from the same study shows the differences in relationships between teenagers and their fathers by comparing those who have had sex and those who have not had sex. The differences are also confirmed in these statistics (Hill and Boydell, 2001).

133. A recent survey from The National Campaign to Prevent Teenage Pregnancy in the USA showed that 88% of young people said it would be easier to postpone sexual activity and avoid teenage pregnancy if they had more open, honest conversations about these topics (The National Campaign's Annual Survey, 2003).

134. The NATSAL survey shows that the non-use of contraception was higher among men and women who did not discuss sexual matters with their parents, and whose main information source appeared to be friends or others (Wellings et al., 2001). The problem appears to be that parents are largely ill equipped to talk to their teenagers, and lacked either the model of how their own parents talked to them, or the confidence to do so. Blake et al., have suggested that: '*The positive effects of parent-child communications appear to be*

mediated by several critical factors: the frequency and specificity of communications, the quality and nature of exchanges, parental knowledge, beliefs and comfort with the subject matter, and the content and timing of communications (for example whether they take place before the young person initiates sexual activity).' (Blake, et al, 2001).

135. Another possible mediating factor between good parental relationships and communication with teenagers, is that poor parental monitoring and communication were related to greater influence of peers on the life of the adolescent. This is often regarded as being an influence in the direction of sexual activity, as opposed to the greater influence of family – which tends to discourage sexual activity (Wilder et al., 2002). Other studies have also shown that parent-child closeness can lead to greater educational achievement, help in the development of social skills, and aid in the development of a greater sense of self worth and competence (Miller, 2002). In other words, it appears that parents may be the key factor in determining where a teenager gets their self-esteem from. If they get self-esteem from their relationship with their parents this is likely to encourage educational attainment. If they do not they are more likely to look for it amongst peers (see Section 2.3.6.).

2.5 The Extra-familial System

136. The extra-familial system refers to the influences on young people outside of the family unit. These include, peer pressure on young people, media pressure and socio-economic factors. According to Kotchick et al., in their review of Adolescent Sexual Risk Behavior, '*…the extra-familial system is in need of greater research attention with respect to adolescent sexual risk behavior for two primary reasons. First, as noted above, adolescence is a period of development characterized by the increasing influence of factors outside the family. Therefore, these influences deserve more attention, so that we may better understand the factors involved in adolescent sexual risk behavior. Secondly, of the three systems, the extra-familial system is the broadest in scope, as it encompasses the larger social context in which adolescents operate. Arguably, this broad context can serve to interact with, augment, or attenuate the influence of variables in the self or family systems, and for this reason must be included for consideration in all aspects of adolescent sexual behavior, particularly as we attempt to discover factors that increase or decrease adolescent sexual risk, and ultimately implement methods preventing such risk…*' (Kotchick et al, 2001). Sections 2.5.1.-2.5.3. are brief overviews of some of these key extrafamilial factors influencing initiation of teenage sexual activity.

2.5.1. Peer Pressure

137. According to research by Mellanby et al., most young teenagers cite pressure from friends and partners as the main reason to initiate sexual activity in their age group (Mellanby et al., 1997). Indeed the growing influence of peers during adolescence is related to the developmental process that adolescents go through (see section 2.3.1. - 2.3.3.). As the adolescent seeks to develop identity beyond the nuclear family, the acceptance and opinion of peers becomes ever more important. Indeed, in this society, sexual behaviour among peers can become a basis for acceptance. In a classic study by Jessor and Jessor they show that in comparing virgins with non-virgins, those who are still virgins tend to have, among other things, a greater value and expectation for independence, and have friends whose views tend to agree less with those of their parents and who influence them more than their parents do (Jessor and Jessor, 1975). DiBlasio and Benda show that a strong predictor of the frequency of sexual intercourse among youth was different peer associations and their behaviour. They go on to ask the crucial question of whether these friends are chosen because of similar sexual behaviour or whether they are selected prior to the initiation of sexual activity thereby encouraging it (DiBlasio and Benda, 1990). The relationship between peers could be mediated by one of two factors either the actual sexual activity of peers, or the perceived sexual activity of peers.

138. The relationship between sexually active peers and sexual activity in an individual is established in reviews of the literature (Kotchick et al, 2001). This relationship between the behaviour of peers and the individual can also be demonstrated for other non-sexual risk behaviour such as alcohol and drug use (Kotchick et al, 2001). Udry has also shown that virgins whose best boyfriend and best girlfriend had had sex were 6 times more likely to become sexually active than those virgins for whom only one best friend was sexually

active. Those with both best friends sexually active were 20 times as likely to become sexually active than a girl whose best boyfriend and best girlfriend had not had sex (Udry, 1990). Research has also shown a difference between male and female adolescents in regard to the actual sexual behaviour of their peers. Behaviour for female teenagers more closely resembles that of their friends, whereas for boys this relationship was not found. This was attributed to girls having more accurate knowledge of the sexual behaviour of peers (Wilder et al, 2001).

139. Not only does the actual sexual behaviour of peers affect adolescents, but the perception of the sexual activity of peers can also affect behaviour. DiBlasio and Benda found that in a sample of youths, those who were sexually active tended to perceive most of their friends as being sexually active (cited in Cohen, 1995). The perception of sexual activity in peers, and its relation to the initiation of sexual activity in adolescents, has been shown in a number of other papers (Kotchick et al, 2001). The perception of the sexual activity among peers is generally overestimated, but efforts to inform young people of the actual figures surely help to dispel current myths. Trost suggests that perception is powerful because people tend to act on their perception rather than on the *"objective"* facts (Trost, 1990).

140. Since peers clearly have an impact on adolescent behaviour, attempts to reduce sexual risk behaviour must acknowledge and seek to cooperate with adolescents in seeking to change behaviour. Culture change will only work when either peer influence is reduced, maybe through the encouragement of greater communication with parents, or when peers are enlisted to change the culture from sexual risk behaviour towards delay and safety within sexual relationships.

2.5.2 Media Pressure

141. The impact of the media on young people should not be underestimated. Young people are in one sense given unparalleled freedom to make decisions in our Western society. At the same time they are victims of uninterrupted mass media influences on their lives, especially in relation to sex. They experience tremendous social pressure to conform to roles defined by the cultural milieu (Cohen, 1995). As Trost points out, in one sense we do not think the media is powerful in itself in directing sexual behaviour and values. But whether it is printed, on the radio or shown on TV, they are all 'truths', especially when they are combined with observing parents, family or peers (Trost, 1990). A number of studies have also cited the media as being the main, or the second main source of information regarding sex (Wellings et al., 1996).

142. Regarding the impact of the media on the adolescent there are two approaches. The first is the *uses and gratifications* approach. It postulates that adolescents use the media for five purposes: entertainment, identity formation, high sensation, coping, and youth culture identification. Secondly, *social learning theory*, mentioned elsewhere, suggests that adolescents learn behaviour by observing others and then reproducing, and reinforcing that behaviour (Chapin, 2000). Both theories offer a rough framework in which to examine the influence of the media on the individual.

143. Magazines are a major source of information for young people. In a recent review of adolescent sexual content in the media in Scotland, it was shown that girls' magazines seemed to provide advice regarding sex, including considerations of when they are ready to start having sex. They also offered advice on contraception and pregnancy. However, as Batchelor and Kitzinger point out, '*there was an underlying assumption that while younger teenagers (i.e. readers of Sugar and Mizz) may not currently be hetero-sexually active, they soon will be (i.e. by the time they read 19)'* (Batchelor and Kitzinger, 1999). Other research has shown that in a sample of 1245 teenagers 12% of 13-15 year-olds would read *19* and 27% would read *More* (a magazine with similar content to 19 and aimed at an older age group) (Boydell and Hill, 2001).

144. Music can communicate through the words of a song, the image and publicity of the performers, or through videos. In one study, 75% of concept videos (videos that tell a story) had sexual imagery and half involved violence, usually against women (Chapin, 2000). How people view such videos is different depending on the individual. A study looking into the effects of race and gender on interpretations of Madonna's videos

showed that black cultural interpretation was very different to that of whites, especially around issues such as sexuality and family (Brown and Schulze, 1990).

145. Television is arguably the most influential medium of communication. Adolescents' exposure to TV is higher than ever and they are the greatest consumers of this kind of media. TV provides the adolescent with an insight into the world of adult sex (which is usually unrealistic), one which, according to Strasburger, has in the USA nearly 14,000 sexual references a year and which involves little use of *'birth control, self-control, abstinence, or responsibility'* adding that *'Extramarital sex is portrayed eight times more commonly than sex between spouses; 94 per cent of the sexual encounters depicted are between people who are not married to each other. Sex frequently is portrayed as being impersonal, emotionless, and exploitative.*' This study has also shown that teenagers are much more likely to believe that what they watch on TV is real. Another study quoted by Strasburger showed that pregnant teenagers were twice as likely to believe that TV relationships were like real-life than non-pregnant teenagers. One study showed that of 75 adolescent girls, the half that were going to become pregnant watched more soap operas before becoming pregnant than the teenagers who would not become pregnant. Moreover, the pregnant girls were less likely to believe that their favourite TV characters would use birth control (60% vs 79%) (Strasburger, 1989). Adolescents interpret TV input very differently depending on the developmental task that is at hand. Chapin suggests that adolescents who are concerned with relationships are likely to turn to the media for information on, for example, kissing since they can gain information without embarrassment (Chapin, 2000).

146. Children are not equally susceptible to sexual imagery. It is becoming apparent that the adolescent's sexual self-perceptions are vital to the manner in which he or she interprets the media. For example, the young person's value system and discussions about sex in the family are both likely to influence how the media are interpreted (Committee on Communications, 1995). This leads to an interpretation on the effect of the media on the adolescent of *'the abandonment of the notion of "massive" effects for conditional effects.'*; in other words the effect is dependent on the development of the adolescent and the tasks they are growing in, the values framework, and sexual self-perception the adolescent brings to media exposure (Chapin, 2000). More is being recognised about the influence of the media on young people. However, the need for cooperation of the media in changing the culture around adolescents and sexual relationships is vital. Sex can very often be presented in a positive light in the media. The problem is that vital issues such as coercion, delay, pregnancy, risk and contraception are rarely discussed alongside these portrayals. Significantly, the UN in their declaration on the Rights of the Child (General Assembly Resolution 44/25, Nov 1989) charged the media with responsibility in their communication to young people. Article 17 states: '*… the mass media …. shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health'*. Without the cooperation of the media, the task of reversing the trend in STIs and teenage pregnancy will not be achieved. Media portrayals need to be ethical in their approach and promote, as stated above, the social, spiritual, moral, physical and mental well-being of the child. The implications of such a charge are discussed in relation to SRE and ethics in chapter 4.

2.5.3 Socio-Economic Factors

147. The relationship between socio-economic disadvantage and increased teenage pregnancy is well established. The Social Exclusion Unit's report *Teenage Pregnancy* (1999) highlighted that the risk of becoming a teenage mother is ten times higher for a girl who is in social class V (unskilled manual) compared with a girl from social class I (professional). Furthermore, a girl is three times more likely to become a teenage mother if she lives in local authority housing of some sort, compared with those who do not. What is often unclear is whether it is poverty itself that leads to teenage pregnancy, or whether teenage pregnancy leads to deprivation (Burtney, 2000) with a combination of both being most likely. Connected with poverty and deprivation there is a low expectations for the future amongst teenagers in such areas: '*…they see no reason not to get pregnant*' (SEU, 1999).

148. In areas of deprivation there is little demonstration of educational attainment. The educational attainment in parents is correlated to educational attainment in their children. The higher the educational attainment

the greater the chance that a young person will delay first coitus. For those without many aspirations, self-confidence and hope for the future, the sense and reality of social exclusion becomes stark. Meyrick and Harris state that the alienation and powerlessness of the lower socio-economic status can lead to what they call '*social anomie'* (Meyrick and Harris, 1994).

149. In the past teenage pregnancy may not have led to social exclusion, but now, with the smaller extended family resulting in less support for the new mother, and the greater emphasis on education and career progress, it is intimately connected with social exclusion. Any attempt to prevent the teenage pregnancy and STI problems in our culture must never lose sight of this vital correlation between many of the issues highlighted in this chapter and socio-economic status. This social context is the one in which all of the above tend to sit in potentially their most damaging manifestations.

2.6 Conclusion

150. This chapter has sought to identify the different factors that influence the manner in which young people initiate sexual activity. Puberty and hormonal factors are clearly a necessary precursor to sexual activity in providing the hormonal stimulus and physical changes that can lead to sexual activity. However, this still does not explain why some teenagers do not initiate sexual activity.
151. Psychological factors leading to initiation of sexual activity are also important. In particular this chapter has considered how sex can be used to fulfil non-sexual needs such as the desire for affection, to ease loneliness or bolster self-esteem. The challenge is therefore to help young people understand the manner in which they can use sex to fulfil non-sexual needs and help them develop alternative strategies for meeting these needs. When considering sexual activity as one risk behaviour among many it has been found that the degree to which a young person is involved in risky activity is higher, the younger the person is. Further, friendship with other young people involved in general risk behaviour (drugs, alcohol etc.) is likely to increase the risk behaviour of the young person. Increased knowledge of potential risk does sometimes reduce the likelihood of the risk behaviour, but this is not always the case. The likelihood of risk behaviour is also related to the cognitive development of the young person, including their ability to anticipate risks associated with behaviours. There is much debate over whether a young person is therefore capable of making wise choices when they are at lower levels of cognitive maturity. What is clear is that one 13 or 14 year olds ability to make a competent decision and anticipate the risk associated with sexual activity will be very different from another young person of the same age. This suggests the importance of SRE being catered towards the individual young person. This could be done, for example, with a greater parental role in SRE. More research is needed, but it is clear that in providing information on sexual activity it must be presented in an age appropriate way that is not completely out of proportion with the young person's cognitive maturity and whether they are approaching puberty or not. Talking about sexual relationships before a degree of cognitive maturity has been reached may lead to increased risk behaviour among many young people.

152. Also under psychological factors related to the initiation of sexual activity are psychiatric problems that are correlated with increased sexual risk behaviour. Connected with this is the correlation between sexual abuse and earlier initiation of sexual activity among young persons who have suffered in such a way. This may be because of deep psychological damage, self-blame and post-traumatic stress disorders. Self-esteem is also related to the initiation of risk behaviour including sexual activity. There is no direct link between self-esteem and risk-behaviour; rather it is where a young person is going to get these needs met that is the issue. For example if the young person gets their self-esteem through peer group acceptance, and if this group is involved in risk activity, then they are likely to initiate sexual activity earlier than young people who meet self-esteem needs through, for example, increased school connectedness, educational attainment and relational closeness to the family (see below). Helping young people have educational goals and increasing school-connectedness may therefore reduce the influence of a peer group associated with risk. Similarly, it is likely that the greater a young person's connectedness to their family environment the lower the influence of peers.

153. The family and parent-child relationships appear to be the greatest factor influencing the level of sexual behaviour among young people. The family structure of the young person is related to sexual activity. If

both parents are present this is associated with lower sexual activity compared with a one-parent household. Also if there is a fair degree of parental monitoring of young people this is associated with lower sexual activity (as long as the monitoring is not excessively overbearing). These factors may be mainly mediated by relational closeness between parents and their children. The greater the quality of relationships between parents and children, the lower the sexual activity and general risk behaviour. Additionally, the family shapes the values of the young person and is the key source of self-esteem that may impact the possible influence of peers in the future.

154. Regarding the extra-familial factors, peer pressure is cited as the greatest influence leading young people to initiate sexual activity. Association with peers who are sexually active is correlated with initiation of sexual activity. It is also significant that the perception of sexual activity among peers is generally over-estimated. Such misinformation needs to be corrected. Changing peer culture towards healthier behaviour would be a major area to address. Media pressure is also a pervasive influence on young people with sexual images used not only to sell many goods but is present in many TV programs. Interpretations of such sexualised content is determined by age, cognitive development and the sexual self-perceptions of young people. The need for accurate messages from the media on sexual relationships should be encouraged. Further, critical viewing of media portrayals of sex, both in the school environment and in the home, may be an important factor in promoting informed choice among young people. Finally, socio-economic factors continue to be correlated with risk behaviour including early sexual activity. Addressing social exclusion remains a major goal in seeking to improve sexual health.

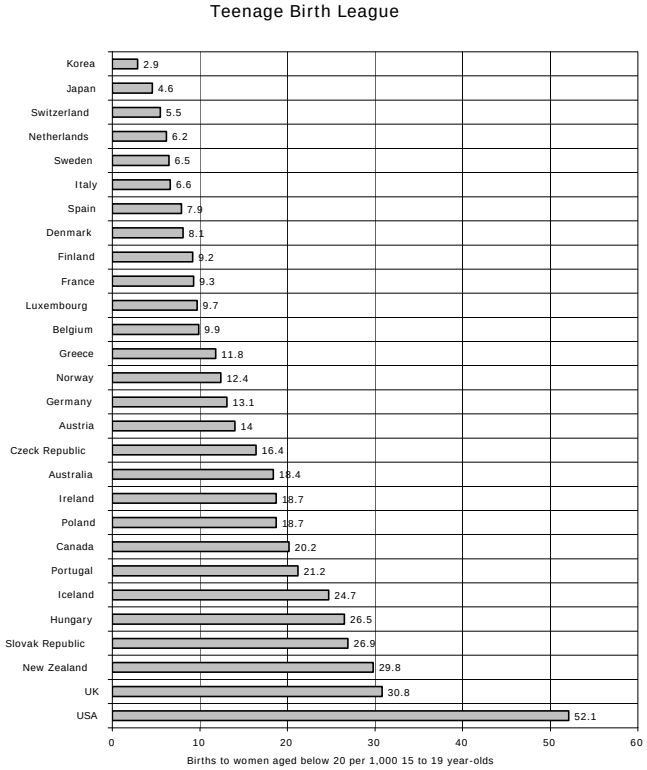
Chapter 3 International Comparisons

3.1 Introduction

155. Chapter 1 *The Scottish Scene* and Chapter 2 *Initiation of Teenage Sexual Activity* have sought to provide some background for this paper's discussion on ethics in SRE and wider sexual health. This chapter also seeks to provide some background to the current debate by looking at some key international comparisons that provide examples of evidence-based approaches that may help in improving Scotland's poor sexual health record.

3.2 The Netherlands: Why is it Successful?

156. The Netherlands, apart from perhaps the USA, has been used as the most relevant international comparison consulted by sexual health professionals seeking a way forward for Scotland. The reasons for its relevance are easy to comprehend for it provides an example of a European industrialised nation that has seen consistently low teenage pregnancy rates for the last quarter of a century. Over this period, for example, the birth rate for girls aged 15-19 has remained at about 40 per 1000 for girls in England and Wales, for Dutch girls the figures have fallen from 8.4 to 4.1 per 1000. (Lewis and Knijn, 2001). When considering the league table of teenage births in rich nations provided by the UNICEF report card of 2001, the comparison of the two nations is stark.



157. The UK is second highest among this sample of industrialised nations, whereas the Netherlands is the fourth lowest. It is important when looking at this graph to see that it represents teenage births, in other words many teenage pregnancies may have ended through either abortion or miscarriage. For example, Finland and Norway may have high abortion rates, thus dampening their birth statistics. The graph also does not account for the number of teenage births that take place in the context of marriages, which may make teenage pregnancies less of a social exclusion risk. Nevertheless the graph does roughly reflect the comparative situation internationally.

158. The UNICEF report highlights the importance of the Netherlands as a key example for all industrialized nations since: *'The Netherlands,…not only has one of the lowest teenage birth rates in Europe but also one of the lowest teenage abortion rates in the developed world. This is a remarkable achievement,… Whilst experiencing the same socio-sexual transformation as other advanced Western economies, the Dutch have managed to reduce teenage births by 72 per cent in 30 years (Sweden and Denmark have achieved very similar reductions but have teenage abortion rates that are approximately four times higher). And as it is clear that this is an achievement that springs not only from the particularities of culture or history but from conscious policy, it is to the Netherlands that most attention has been directed in the search for 'what works.'* (UNICEF, July 2001). The degree to which the reduction is through *'conscious policy'* is a matter of debate, for rates have remained relatively low compared to Britain throughout this 25 year period, and have continued to be low. Nevertheless, the Netherlands example is important and rightly deserves attention.

159. Influential research from British academics including Jane Lewis, Trudie Knijn and Roger Ingham has further emphasised the Netherlands as a model to follow. The importance of the Dutch model for Britain has been established on the national consciousness through high profile media coverage including TV, radio and Newspaper articles such as: *'Sex talk 'reduces teenage pregnancy rate'* which announces the launch of a paper by Lewis and Knijn stating: *'Teenage pregnancy in Britain will remain far above European levels because sex is regarded as "dirty" by too many parents and schools…Low Dutch rates [of pregnancy] are attributed to more talk about sex between parents and children and more education in schools both about the physical and emotional dimensions of sex.'* (Walker, Guardian, 2002).

160. A number of reasons are given for the Netherlands record in teenage pregnancies over the last 25 years including the one given in the above newspaper article concerning more openness in discussions about sex. Roger Ingham suggests that along with a number of other countries in Europe the Netherlands has a better record because they: '… *have an earlier and more open approach to sexual issues in schools and in families. This is associated, in the Netherlands at least, with greater levels of discussion and forward planning between partners, later ages at first intercourse, more effective contraceptive use, and lower levels of subsequent regret.'* (Ingham, 2000)**.** Similarly the UNICEF report suggests: *'In general, studies of the Dutch experience have concluded that the underlying reason for success has been the combination of a relatively inclusive society with more open attitudes towards sex and sex education, including contraception.'* (UNICEF, July 2001). In other words, the reasons that are commonly given could be summed up as (a) earlier and more effective sex education, (b) greater cultural openness to talk about sex both in schools and families, and (c) greater forward planning and effective contraception use. Each of these points will be analysed in turn.

3.2.1. Superior Sex Education

161. Superior sex education is often postulated as a reason for the difference between the UK and the Netherlands. However, what this exactly means is often difficult to determine. Lewis and Knijn point out from their comparative research of sex education policy in England and Wales, and the Netherlands, that any differences in the materials themselves are minimal at best. What can be said to be different is the general atmosphere in which the teachers operate, with a greater freedom in what they teach, and parents who evidently put more trust in the schools than would be the case in Britain. Sex education is also less politicised in the Netherlands than in the UK (Lewis and Knijn, 2002). Over the last 25 years one must also take into account that formal sex education in schools had not been fully developed in the Netherlands until relatively recently (Lewis and Knijn, 2001). Moreover, Van Loon, looking at a sample of schools in the Netherlands from across the spectrum, found that sex education was actually taught later in most

schools than in the UK. For Dutch young people it would start when they are at least 10 years-old, but more commonly when they are 11 or 12 years-old. In Britain, if it is offered in primary schools, it mainly targets 10 and 11 year-olds (Van Loon, 2003).

162. A closer look at what this environment may be that enables sex education to be taught better is therefore necessary. Again Lewis and Knijn in their 2001 paper note that there were quite a few differences between the Dutch students and their English counterparts regarding their behaviour in the classroom. They point out that jokes were cracked in the Dutch classrooms during sex education but that the lesson suffered less from the more crude comments characteristic of English classrooms. Further, boys seemed to behave particularly disruptively in the English classes compared to the Dutch. However, when interviewed privately they responded in a thoughtful manner, suggesting a potential greater influence of peer pressure on boys in the English context. Lewis and Knijn emphasise that if school is the main source of information regarding sexual relationships for boys then this does not bode well; *'the behaviour of boys in the classes we observed is a source of concern'* (Lewis and Knijn, 2001).

3.2.2. A Culture of Openness

163. A culture of openness is said to be characteristic of both Dutch families and the school context. Regarding the league table of births shown above, the UNICEF report suggests the following way to interpret the graph: '*One of the keys to interpreting the league table of teenage birth rates therefore seems to be that countries with low teenage birth rates tend to be either countries that have travelled less far from traditional values or countries which have embraced the socio-sexual transformation but have also taken steps to equip their young people to cope with it. By the same reasoning, those countries with the highest teenage birth rates tend to be those that have marched far along the road from traditional values whilst doing little to prepare their young people for the new and different world in which they find themselves.*'

164. The UNICEF report goes on to clearly put the Netherlands in this bracket of nations that has both embraced the socio-sexual revolution and has equipped its young people to cope with it. They state that '*…the Netherlands, has travelled far down the road from traditional values but have achieved a rapid fall in teenage birth rates by being fully exposed to the forces that have tended to make early childbearing a disadvantage, by being relatively inclusive societies, and by making conscious and apparently successful efforts to prepare and equip their young people to cope with a more sexualised society*.' (UNICEF, 2001). This interpretation raises some important questions, 'What is this openness that is being described?' and 'How is it characterised?' Lewis and Knijn emphasise that it is not to be regarded as being more permissive (Lewis and Knijn, 2002). In addition, this travelling '*far down the road from traditional values'* is problematic, for in one sense the intellectual climate of the Netherlands would be regarded as liberal, and yet the traditional family unit remains relatively strong. This is very similar to France, where the intellectual and religious climate could be seen as liberal, but strong traditional family units and communities remain.

165. One area of openness that is clearly established is that of communication between parents and young people. Dutch students appeared to be more reluctant to rely on schools for sex education in comparison to English students, suggesting a greater reliance on the home environment (Lewis and Knijn, 2001). Research by Amy Schalet comparing parents in the Netherlands with those in the USA (arguably more like those in the UK), showed that American parents were more confrontational and therefore controlling in issues relating to sexuality. In contrast, Dutch parents were more '*pragmatic and consensus-orientated'*, and that communication would be regarded as healthier in Dutch homes (Schalet, 2000).

3.2.3. Better Forward Planning

166. Better forward planning and effective contraception use has also been suggested as a major difference between the Netherlands and the United Kingdom. The UNICEF report highlights the fact that young people in the Netherlands are generally older at first intercourse, experience less regret, and use contraception more and with greater effectiveness. They forward plan and discuss more between partners (UNICEF, 2001). According to one study, 85% of sexually active young people in the Netherlands use a

contraceptive (Ketting and Visser, 1994). Lottes claims that in comparison with the USA, condom usage in the Netherlands is not that different, what is different is usage of the pill. 67% of sexually active female adolescents used the pill at their most recent intercourse, compared with 20.5% in the USA (Lottes, 2002). It is however important to emphasise that although condom use appears to be more effective in the Netherlands than the UK, STIs are also being noted for their increasing incidence. With a population of about 16 million, the Netherlands has about 100,000 new cases of STIs a year. (News Section, BMJ 1999).

167. Lottes draws out another important factor, that of better forward planning, and hence interactional skills that help to avoid high-risk sexual behaviour among adolescents in the Netherlands. She quotes Rademachers' research which shows that among Dutch girls who experienced an unwanted pregnancy, most had given over control in decisions regarding contraceptives to the boys (Lottes, 2002). Indeed, Lewis and Knijn found that English pupils were more fatalistic about sex, that it happened on impulse and that the hormones just took over, often with the aid of alcohol. A major factor behind teenage pregnancy is girls being coerced by boys to have sex. For Dutch adolescents, drunkenness and sex were noted as reasons for which teenagers got pregnant, but only as something that happened to others, not themselves. Further, there appears to be greater confidence among Dutch students to protect themselves, and greater emphasis on helping students decide what they want in life and hence how they will act (Lewis and Knijn, 2001). Such fatalism among British students can signify general low self-esteem, linked to low aspirations and hope for the future. The strategies employed to fulfil the need for self-esteem include greater susceptibility to peer pressure among young people who associate with, for example, a street culture associated with greater risk behaviour (see Chapter 2, Section 2.3.6.). It may be that young people in the Netherlands are less influenced by peer pressure, are potentially more connected to the school, have better relationships with their families and have greater aspirations for the future.

3.2.4. What has therefore happened in the Netherlands?

168. When looking at the Netherlands and its relative success, the lack of research makes conclusions difficult. More studies are certainly needed to better understand the differences between the UK and the Netherlands. First, sex education seems to be more different in the classroom environment which seem more disrupted in the UK compared to the classrooms in the Netherlands. This may be a sign of greater susceptibility to peer pressure among UK pupils. Second, a greater cultural openness seems to be a characteristic difference, largely in terms of good communication between young people and their parents. Third, there is more forward planning, negotiation, and condom use among Dutch young people. Common policy initiatives in the UK therefore emphasise building skills of negotiation and forward planning into young people. However, as argued earlier, maybe this difference is mediated by greater levels of self-esteem and future expectations among young people in the Netherlands and therefore lower levels of susceptibility to peer pressure and risk behaviour. Of further significance, and not really mentioned much in the literature, is the difference in the strength of the traditional family unit in the Netherlands. As shown earlier (see Chapter 2, Section 2.4.1. - 2.4.3.), family background is correlated with sexual risk activity. In the year 2000, single parent families made up 26% of all families with children in the UK. For the Netherlands the figure is 5.7% (Van Loon, 2003). Such differences are important. Family background is statistically related to sexual risk activity and is therefore an important difference that needs consideration. Arguably, the Netherlands has not moved as far down the road from traditional values as the UNICEF report suggests. Indeed, traditional values remain strong at the family level. More research is certainly needed to look at the influence of the stronger traditional family unit in explaining the differences between the Netherlands and the UK. It is also vital to seek to quantify the apparent differences in self-esteem and the strategies employed to meet self-esteem needs between young people in the UK and those in the Netherlands. This may also prove to be an important factor that has been under emphasised when considering the Dutch experience.

3.3 The USA: The Abstinence Debate

169. As can be seen from the Teenage Birth League table in section 3.2 the USA is by far the worst of the rich industrialised nations in terms of its teenage pregnancy and birth statistics. With 52.1 births per 1000 girls aged 15-19 years-old, compared with the next highest, the UK with 30.8 births per 1000 girls aged 15-19 years-old. The USA, despite such bad statistics, remains an important case study for Scotland. The reasons are, in the first place, the similar culture of the USA and Scotland. Scotland is indeed heavily influenced by American culture, especially youth culture. The USA is therefore the country outside England and Wales that probably most resembles Scotland culturally, although this should not be overstated. Second, the USA, as well as having the largest pregnancy rate among the rich nations, has also seen rapid falls in its pregnancy rates amongst 15-19 year-olds, and is having considerable success in its battle to reduce teenage pregnancy. Third, and perhaps most importantly, the USA is the source of most of the best research into sex education and adolescent sexual activity that is available worldwide. For example, it provides much of the latest evidence for the effectiveness of new approaches to sex education.

170. The importance of the USA should however be tempered by the often polarised debate, which can often degenerate into cultural clashes and straw-man argumentation. Characterisations can rule, in the midst of which the evidence-base and real debate can be lost. Perhaps the most controversial of debates at present is over abstinence-only sex education programs and contraception promotion.

3.3.1. Setting the Scene

171. The history of sex education programs is outlined by Thomas in his review of abstinence-based programs in the USA: *'The first generation of adolescent pregnancy prevention programs began in the 1970s with a focus upon increasing knowledge about sex and the risks and consequences of teen pregnancy. The second generation of programs included similar information but placed greater emphasis upon values-clarification and skills in decision-making and communication. The evaluation of these programs were unable to demonstrate a lessening of sexual risk-taking behaviors in their target audience. In reaction to these programs and partly owing to a change in the political climate of the nation, a third generation of programs stressing abstinence to the exclusion of information about contraception was promoted by the Adolescent Family Life Act of 1981 (Title XX). The fourth-generation programs were essentially syntheses of the previous three generations. Emphasizing prevention of human immunodeficiency virus (HIV) transmission, these programs combined a strong abstinence message with training in communication and negotiation skills as well as instruction in sexuality and contraceptives. These programs were better grounded in theoretical approaches to behavior change and were generally subjected to evaluations that were more rigorous.'* (Thomas, 1999).

3.3.2. The Abstinence Debate

172. There are two broad approaches to abstinence education, the *abstinence-only* approach and the *abstinence-plus education* approach (also called comprehensive sex education). *Abstinence-only education* could be defined using the guidelines for funding for abstinence-only programs set up by Congress under President Clinton in 1996 where a funding program called Title V, Section 510, released $50million annually for five years for funding to states to set up programs that teach the abstinence-only approach. The guidelines for gaining funding for an abstinence-only program were:

- *Have as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.*
- *Teach abstinence from sexual activity outside marriage as the expected standard for all school-age children*
- *Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems*
- *Teach that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity*

- *Teach that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects*
- *Teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society*
- *Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances*
- *Teach the importance of attaining self-sufficiency before engaging in sexual activity*
(Maynard and Devaney, 2002.)

173. *Abstinence-plus education* could be defined as a program that promotes abstaining from sex until the young person is older. They communicate the value of abstaining from sex, including the health, social and psychological benefits. Further, abstinence-plus education programs would also teach about contraception for those that will become sexually active. Abstinence-plus education programs can also be called comprehensive sex education. The breadth of what can come under the term abstinence-plus needs to be acknowledged, for some programs that are described as abstinence-plus education may major on teaching about contraception and skills development while abstinence plays only a limited part and vice-versa.

174. The debate over the two forms of sex education has relied on characterisations of the other, including that abstinence-only programs use fear-based approaches (Kantor, 1992). The problem is that there is no one standard of what an abstinence-only program looks like or what the average program would promote as abstinence (Goodson et al., 2003). Recent studies show that about 34% of schools in the USA teach abstinence-only sex education with the rest teaching abstinence-plus education in its broadest definition (Wallace, 2000). We have a rough idea of what an abstinence-only approach may entail (outlined above), but what may come under abstinence-plus education can vary a lot depending on the degree to which abstinence is the focus.

3.3.3. Does the Abstinence Message Work?

175. Many have sought to determine the effectiveness of the abstinence approaches. Perhaps the most reliable summary of the effectiveness of the abstinence approach is the work of The National Campaign to Prevent Teen Pregnancy led by Douglas Kirby. The organisation was launched by Hilary Clinton in 1996 and is a non-governmental organisation that has charged itself with the task of reducing the teenage pregnancy rate by one third between 1996 and 2005. It is committed to producing, and publicising the evidence base for the different approaches to sex education to enable more effective program implementation. One of its most recent publications summarises the current evidence base for the abstinence-only approach. The paper looks at programs that have been proposed by another organisation, the Heritage Foundation, as being examples of abstinence-only programs that work (Kirby, Oct 2002). The National Campaign sets high standards for evaluations that will be accepted as evidence for the effectiveness of programs. For example, only programs with a sample size of at least 100 are accepted. Actual behaviour must be measured not merely the intention to act in a certain way, and the follow up of behaviour change post-intervention must be at least 6 months. Also, proper statistical analysis should be employed, for example, a randomised control trial (Kirby, Oct 2002).

176. Of the ten abstinence-only programs that the National Campaign report highlights, three programs meet the statistical conditions and showed positive results. In the first instance, the Teen Aid, Sex Respect and Values and Choices programs were found to be effective only for the most permissive of high school students, but for the rest there was little indication of the effectiveness of the program (Kirby, Oct 2002).

177. Secondly, the Postponing Sexual Involvement program showed some promising results, especially in its implementation in Atlanta, Georgia, where there was some evidence for a delay in the initiation of sexual activity. The program did appear to have a lasting effect with 24% of the students having done the program initiating sexual activity in the second year after the intervention, compared with 39% who had not done the program (Howard and McCabe, 1990). It is however noted that its implementation in Atlanta, Georgia, was as an abstinence-plus program with a secondary component on contraception added to the Postponing Sexual Involvement curricula (Kirby, Oct 2002).

178. Thirdly, and most significantly, there is the Not Me, Not Now program from Monroe County New York. The program is a community wide mass communication program promoting abstinence from sexual activity including posters distributed in schools, on billboards, in advertisements on TV and radio, and educational material for parents. The Postponing Sexual Involvement Curriculum was used in a few schools in the county where this program was running. The county-wide rates for sexual activity, compared to other similar upstate New York communities, among youth under 17 years-old did fall, but not significantly. For young people under-15 years-of-age there was a significant reduction in sexual activity. The only possible weakness was that it could have been other factors that reduced the sexual activity rate in the community. However, this is unlikely to be a major factor and Kirby goes on to say: '*…people who want to implement large mass communication abstinence campaigns should seriously consider putting this program in place, because among abstinence-only programs, it has the strongest evidence to date that it may delay the initiation of sex among younger teens and even reduce teen pregnancy.'* (Kirby, Oct 2002).

179. Kirby argues that clear behavioural guides are crucial for the effectiveness of sex education programmes. In addition, writing about the National Campaign to Prevent Teenage Pregnancy in the USA and the lessons it has learnt in seeking to reduce teenage pregnancy rates, he points out the vital importance of using the media to change cultural messages about sex. He states, among other things, that: '*…recognition that [sex education] programs must compete with many other influences, make it clear that programs alone cannot make lasting progress in reducing teenage pregnancy. Using the media, including popular television programs and magazines, to change broader cultural messages about sex is also needed.'* (Kirby, Halfway There, 2001).

180. Other programs noted for good results, but which did not fulfil the evaluation criteria of the National Campaign, included the Virginity Pledge Movement. The pledge to virginity amongst girls, did seem to delay the onset of intercourse in terms of time by 34%. There were limitations however. Firstly, contraception use was lower for those who took a pledge (Bearman and Bruckner, 2001). Secondly, the pledge was only effective for girls over 14 and under 17 years-old. Further, the pledge had no significant impact if there were no peers who pledged or if more than 30% of peers pledged, in which case the pledge became ineffective (Kirby, Oct 2002). The virginity pledge, though successful under certain circumstances, is not a universal strategy.

181. Beyond the programs noted by Kirby, a randomized control trial comparing a safe sex and an abstinence-only HIV risk-reduction intervention among African-American adolescents found that at the 3 month follow-up for the abstinence intervention, young people were significantly less likely to report sexual activity. These promising results were not continued for later follow-ups, with the only significant difference being the more frequent condom use in the safer sex interventions at 6 and 12 month follow-ups. The author emphasises, amongst other things, the importance of future research seeking to increase the longevity of these promising early effect of abstinence (Jemmott and Jemmott, 1998).

182. Another interesting program is Reducing the Risk, a program regarded as taking an abstinence-plus approach. At the 18-month follow-up of the students who had received this intervention, 29% had initiated sexual activity, compared with 38% of the students in the control group. Those who did have sex were less likely to have unprotected sex at last intercourse than those in the control group (9% vs.16%) (Thomas, 1999).

183. Another interesting development in the USA is the use of homework assignments to involve parents in their child's sex education. Research from the USA (Blake et al., 2001) shows the potential benefits of utilising homework assignments to aid parent-child communication. The assignments were aimed at young people who had not yet initiated sexual activity with the collaborative goal of encouraging delay. Adolescents who completed the homework assignments with their parents were found to have stronger intentions to delay, greater self-efficacy (skills and confidence) to refuse sexual advances, and the greater likelihood of the behavioural intention to delay sexual activity. The weakness with these findings is the self-selection bias. Those parents who completed homework assignments with their children were more likely to have the better relationships and more communication with them about sexual issues. Nevertheless, the findings are encouraging and such intentions may lead to longer-term changes in behaviour. The homework assignments concentrated on helping the parents and teenager discuss personal

topics, including getting the parent to share their experiences of adolescence. They discuss the reasons for delay in having sex and the reasons for having sex, and go on to look at issues such as peer and media pressure together. Importantly, they also focus on self-esteem, including looking at their positive qualities and having goals for the future. (Blake et al., 2001). Such approaches could be more carefully considered for possible incorporation into Scottish SRE.

184. Regarding the debate over funding for abstinence-only programs it will be largely determined by the findings from a forthcoming report from Mathematica Policy Research, an independent research organisation, commissioned by Congress to carry out an evaluation of these programmes. Early implementation findings in a 2002 report highlight the innovative manner in which states are using the funds to promote abstinence as the healthiest option for young people. The report also emphasises that most programs are much more than the *'Just Say No'* characterisations with advanced programs focusing on: self-esteem, decision making, communication, formulating goals, withstanding social and peer pressure, preventing STIs, developing relationships and understanding development and anatomy. Participants are reporting favourable responses to the programs. The problems being experienced included tackling peer pressure, bridging the communication gulf between parents and children, and establishing partnerships with schools (Maynard et al., 2002). The findings from the forthcoming evaluation will be highly reliable statistically, and are expected to show promising results among some programs.

185. The ideological debates about abstinence teaching and whether it is abstinence until marriage that should be taught or not and the manner in which contraception is presented in programs - tends to take the focus off the most important lessons from the USA that abstinence at the centre of SRE programs can and does work. What is emerging is clear evidence for the effectiveness of the message of abstinence among some of the best programs. In the words of Douglas Kirby, *'"The jury is still out"*, in regard to abstinence-only programs, but he continues: *'Increasingly it seems likely to this author that sooner or later studies will produce strong evidence that some abstinence-only programs are effective at delaying sex and that others are not.*' (Kirby, Oct 2002). However, it is important to recognise that the abstinence-based approach is already established as a feasible message for SRE programs through the evidence for the effectiveness of abstinence-plus education programs. That is, programs whose main focus is delay but with additional teaching on contraceptives for those who are sexually active.

3.3.4. What has Caused the recent Decline in Teenage Pregnancy?

186. Despite having the highest teenage pregnancy rate among industrialised nations, the USA has seen a major decline over recent years in its pregnancy rate amongst 15-19 year olds from a peak in 1991. For example, from 1991 to 1995 the number of pregnancies per 1000 15-19 year-olds fell from 115.8 to 101.1 (Mohn et al., 2003). At the same time the abortion rate fell from 40.6 to 29.2 per 1000 in 15-19 year-olds (Singh and Darroch, 2000). The debate over the reasons for the decline in this period, and its continuation up to 1999, has been hotly contested. In a report from the Alan Guttmacher Institute it was claimed that 25% of the decline in the teenage pregnancy rate was due to increased abstinence from sexual activity and 75% due to increased use of more effective contraception (Singh and Darroch, 1999). Another study, from the National Campaign to Prevent Teenage Pregnancy, said that between 50% and 80% of the fall was due to increased contraceptive use, and between 20% and 50% of the decline to abstinence (Flanigan, 2001). However, new research has suggested a different story for the decline (Mohn et al., 2003).

187. Mohn et al., criticised the above studies on a number of fronts. Firstly, the peak year for the teenage birth-rate is 1991, in the middle of the time frames of these studies. Secondly, they define teenagers who are at risk of pregnancy as those who have already had sex. This ignores the fact that some may choose to abstain from sexual activity, even if they have already had sex. Thirdly, they treat sexually active teens together when in reality many can be married, and therefore are very different both in the likelihood and in the consequences of pregnancy. Mohn et al's study seeks to rectify these weaknesses and to look at the changes in teenage pregnancy statistics from 1991 to 1995, seeking to discern the importance of marriage, and defining those at risk of having a pregnancy as those girls who have had sex in the last year, thus allowing those who have previously had sex to be presently choosing abstinence. They take data on sexual behaviour histories from the *National Survey of Family Growth* and compare single teenagers who are sexually active to those who are not currently sexually active (abstinent). Among single 15-19 year-old

girls the pregnancy rate fell from 95.8 per 1000 in 1991 to 86.8 per 1000 in 1995. This was a reduction of 9 pregnancies per 1000 over this period. In the same period, the abstinent sub-population increased from 53% to 56%. This resulted in 6.1 of the 9 fewer pregnancies from 1991 to 1995 being due to abstinence. This is 67% of the reported decline in teenage pregnancies. At the same time the pregnancy rate amongst sexually active single teens decreased from 203.7 per 1000 to 196.9 from 1991 to 1995. This adds up to 35.3% of the decrease of 9 pregnancies per 1000 from 1991 to 1995.

188. As stated earlier, among all teenage girls the reduction in the number of pregnancies was from 115.8 per 1000 towards 101.1 per 1000 in 1995. The 15-19 year-olds pregnancy rate amongst married girls fell from 519.4 per 1000 in 1991 to 455.6 per 1000 in 1995. With fewer teenagers getting married the reduction in overall pregnancy rates among single and married 15-19 year-olds reflects all the above factors. Thus, Mohn et al., conclude that *'the two factors contributing to the greatest decline in the overall teen pregnancy rate are the increase in single teens abstaining from sex and the decrease in the proportion of teens who were married.'* They calculate that 39.3% of the overall pregnancy rate decline is due to greater abstinence among young people. This is a similar figure to the other studies cited above. What is different is that the rest of the decline is not automatically presumed to be increased contraceptive use. 23.8% of the decline was because of the reduction in the number of young people getting married. In addition, the reduction in the pregnancy rate amongst those young girls who were married was significant. After these factors have been accounted for only 20.7% of the decline in the pregnancy rate from 1991 to 1995 could be said to be because of contraception among those who were sexually active. As Mohn et al., go on to point out: *'… even this decrease may be due to less frequent sexual activity as well as improved contraception.'* (Mohn et al., 2003). Although contraception is a factor in the fall in teenage pregnancy, it cannot be stated to be 75% of the reason for the fall in teenage pregnancy over this period. If anything, the figure is likely to be below 20.7%. Overall, delay or abstinence from sexual activity is acknowledged as an important factor in reducing teenage pregnancy and sexually transmitted disease in the USA with 39.3% of the fall in teenage pregnancy from 1991 to 1995 being due to these behaviour changes.

3.4 Uganda: One Country's Fight Against AIDS

189. The story of Uganda's fight against HIV/AIDs is a remarkable one that deserves attention, for it provides an example of a country that has had tremendous success in fighting off the pandemic. According to Hogle et al, HIV prevalence peaked in 1991 at 15% and has fallen to 5% in 2001. Such a decline has attracted much attention and scientific scrutiny. They go on to point out that '*Uganda's falling HIV prevalence is likely not due merely to measurement bias or a "natural die-off syndrome" but rather mainly to a number of behavioural changes that have been identified in several surveys and qualitative studies'* (Hogle et al., 2002). Figures for pregnant women testing positive for HIV, usually representative of national rates, fell from 21.2% in 1991 to 6.2% by 2002. This is contrasted with Kenya that has rates at 15%, Zimbabwe at 32% and Botswana with 38% of pregnant women being HIV positive (Allen, 2002). More local studies of individual HIV/AIDs projects have found some remarkable changes. One such project, a school-based AIDS education program in Soroti District, showed that among 13-16 year-olds, self-reported sexual activity among boys dropped from 61% in 1994 to 5% in 2001. For girls the equivalent figures is a drop from 24% in 1994 to 2% in 2001. According to Edward Green, other non self-reported statistics back up this data (Green, Senate committee, 2003).

190. The debate as to the causes of the decline in the prevalence of AIDs in Uganda has been very active over the last few years with some emphasising the importance of abstinence from sexual activity, others emphasising monogamy among married and unmarried couples, and still others emphasising the importance of condom use. As is often the case, the debate has centred on reactions and counter-reactions, based on ideological differences. The Ugandan story has become a battle-ground between conservative campaigners emphasising abstinence-only programs, and liberal campaigners emphasising the importance of condom use.

191. So what has been the cause of the decline in AIDS prevalence in Uganda? Research by the Alan Guttmacher Institute using the only nationally representative data available the *Demographic and Health Surveys*, came to a number of conclusions. They separated the reasons for the decline into three categories

(1) Abstinence, (2) Multiple-partner declines and (3) Condom use. The surveys cover reproductive-age women from 1988 to 2000 and men from 1995 to 2000 with the hope that they will show some national patterns to understand the decline in HIV prevalence (Singh et al., 2003).

3.4.1. Abstinence from sexual activity

192. The following pattern was found. For young girls 15-19 years-old there were declines in the number who started sexual activity. A similar, though moderate, decline was found for men aged 18-19 years-old in the same period. However, this was countered by moderate increases among those who were experienced sexually and who currently had a sexual relationship. Abstinence was therefore seen as having a moderate effect on HIV prevalence declines (Cohen, 2002). Thus the data shows that abstinence was effective for non-sexually experienced girls, but that there was limited evidence for its effectiveness outside this group (Singh et al., 2003).

3.4.2. Multiple-partner declines

193. Regarding multiple-partner declines data was only given from 1995 to 2000. The proportion of unmarried sexually active women who had more than one partner within the past year declined across all age groups. For men and women who were sexually active and married there appeared to be little change in the figures for multiple-partners. The conclusion is that monogamy among unmarried women was a significant factor in HIV reduction (Singh et al., 2003).

194. Establishing the importance of the reduction in multiple-partners research from more localised studies backs up its importance. National figures from the Demographic and Health Surveys can miss the evidence coming out from local AIDS projects that have witnessed extraordinary success. One such study states that for men, those reporting two or more partners declined from more than 70% in 1989 to between 15% and 20% in 1995. Among women, the number reporting two or more partners dropped from 18% in 1989 to 2.5% in 2002 (Carter, 2003). Another Anglican run AIDS project in Kampala found that in 1995 those reporting two or more sexual partners declined from 86% to 29% for men, and from 75% to 7% for women (Green, 2003). Green, a senior researcher at the Harvard Centre for Population and Development Studies continues by saying that *'…the reduction in the number of sexual partners…was probably the single most important behavioural change that resulted in prevalence decline. Abstinence was probably the second most important change.'* (Green, 2003). Thus, multiple-partner decline, known as *'zero-grazing'* in Uganda, (faithfulness to one partner) was seen as crucial to the decline. Ugandans reported in 1995 that 95% of them had either one or zero partners in the last year (Green, New York Times, March 1st 2003). When Ugandans were asked what was the main element of their personal activity against AIDS, …faithfulness to one partner was the most common answer for all age groups apart from 15-19 year-olds for whom the answer was, abstaining or delaying, with fidelity to one partner the second highest answer (Green, 2003).

3.4.3. Condom use

195. Condom use for all sexually experienced women increased from 3% to 15% for the period 1988 to 2000. For all sexually experienced men condom use for the period 1995 to 2000 increased from 26% to 41%. Among married men and women, condom use remained small. The conclusion given was that condom use among unmarried sexually active men and women was a significant factor in the HIV decline in Uganda (Singh et al., 2003).

196. However, when interpreting the above figures care needs to be taken. The Alan Guttmacher Institute acknowledge that although the above data are insufficient to provide *"a precise assessment or ranking of the relative importance of each of the different factors."* (Cohen, 2002), they do, however, suggest that a reduction in the number of multiple-partners and an increased condom use can at least be seen to be the major reason for the decline in HIV/AIDS (Cohen, 2002). The problem is that this can be established for multiple-partner declines, but not for condom use. Summarising a report by USAID called *'What Happened in Uganda'*, Africa News states *'…researchers say condom promotion "has played a key but*

evidently not the major role" in reducing infection rates. Their argument is that HIV prevalence started declining in 1992. This, they say, must have been the result of a reduction in new infections in about 1989. By that time, they argue, very few people were using condoms. The researchers, however, agree that increased use of condoms during the mid and late 1990s must have placed an additional muzzle on the virus that causes AIDS.' (Africa News, 2002). Condoms cannot therefore be claimed to be a major cause of the decline in HIV in the late 1980s and early 1990s. It must however be noted that among the more high risk groups, prostitutes, gay men and other groups, AIDS education and condom use has been promoted, with condom use increasing from virtually zero to a figure of around 95% among prostitutes in Kampala (Rosenberg, 2003). The important point may be that condom use is highest amongst those who are most at risk.

3.4.4. How did Uganda do it?

197. So how did Uganda achieve such a large reduction in HIV prevalence? Change started from the top of Ugandan society. In 1986 President Yower Museveni, faced with an awareness of the terrible toll AIDS was taking on the population, led nothing less than a nationwide crusade against the virus. The message was low-cost and simple it was called the ABC approach. A is for abstain from sexual activity, B is for be faithful to one partner, known as 'zero-grazing', and C is for contraception if one fails to do A and B. Everyone from the President down was to communicate this message. It was promoted through means such as billboards, the radio or in the classroom. As one academic who studied Uganda has put it *'the country…reacted to the epidemic as if it were World War III'* (Rosenberg, 2003). In a paper by Hogel et al., they cite a number of reasons for the decline, including the fact that by 2001 there were at least 700 agencies working on HIV/AIDS across the whole of Uganda. They also noted that as of 1986, the National AIDS Control Program was set up, which organised the billboard campaigns, printed material, and conducted local training and community mobilization against HIV. Communication was simple and 'low tech' which allowed for the involvement of people on the ground including, political leaders, religious leaders and teachers (Hogle et al., 2002).

198. Women were also noted as a target group for HIV/AIDS awareness. As many have noted, women were not culturally empowered to resist the pressure to have sex from men. Poverty would often drive women into compromising situations whereby they would give sexual favours to men. Fatalism about the disease also dominated (Borzello, IDRC). According to Sophia Mukasa Monico, a Ugandan working with the Global Health Council, women especially, were the ones to change. This included taking responsibility for their own lives, increasing in faithfulness to their partner and, according to Mukasa Monico; '*Wives told their husbands to be faithful, use a condom, even in marriage…*' (Carter, 2003).

199. A few other reasons for the decline deserve a mention. Hogle et al (2002) consider the voluntary counselling and testing for HIV to be important. This included same day results for HIV tests, as well as help and advice for those who came in regardless of the test result. Also mentioned is the key role played by religious organisations including the significant support of religious leaders in the running of local projects, many of which have been outstanding examples of AIDS care and education (Hogle et al., 2002).

200. Overall, it is difficult to get beyond the importance of *'zero-grazing'* or faithfulness to one partner, in the story of Uganda's HIV/AIDS prevalence decline. Uganda provides an example of a country that was mobilised to fight AIDS in the most extraordinary manner, and has demonstrated to the world that behaviour change is possible when the stakes are high. What can Scotland learn from such an example?

3.5 Conclusion

201. This chapter has considered three international case studies from which lessons can be learnt and applied in Scotland. The Netherlands, the USA and Uganda have all adopted different approaches to sexual health education. Overall the importance of family relationships, the benefits of an explicit emphasis on abstinence backed up by access to information on contraception, and the emphasis within the ABC approach on being faithful to one partner emerge as the key variables.

202. The Netherlands is often cited as an example to follow as it has experienced a similar socio-sexual revolution to the UK. The UNICEF report suggests that the Netherlands, like the UK, has travelled down the road from traditional values yet has been better able than the UK to prepare its young people to cope with this revolution through a high degree of cultural openness about sex both within the family and at school. It is claimed that this openness, accompanied by superior sex education, affects the decisions young people make to delay having sex, to use contraception well when they do have sex and to be less fatalistic and therefore avoid sexual risk-behaviour.

203. However, this chapter argues that the evidence suggests that although cultural openness is a key difference, this openness is not more permissive according to studies. Rather, a significant factor may well be the influence of the more traditional family structure in the Netherlands as compared to the UK. It appears that the Netherlands has not moved as far down the road from traditional values as the UNICEF report suggests. As argued in Chapter 2, Section 2.4.1-2.4.3 parental influence is a key factor correlated with sexual risk behaviour. The key ingredient in the Dutch experience may well be due to a number of factors: that discussion about sex is in the context of positive relationships between children and their parents, and that the young people have goals, aspirations and ambitions for the future which has the effect of reducing fatalism and increasing contraceptive use. Additionally, it would appear that there are considerable differences in levels of self-esteem among young people in the Netherlands when compared to the UK. More research is needed concerning the Dutch experience and the key determinants that affect sexual health outcomes. It is not sufficient simply to conclude that increasing cultural openness in addition to earlier and more comprehensive sex education can be simply transplanted to Scotland and that a similar situation to the Netherlands will emerge over time.

204. In the midst of a polarised debate about abstinence-only programs and the place of contraception education, it is easy to miss the point that there are abstinence-based approaches that are proving effective in the USA. These are far more than the characterisation of a *'Just Say No'* approach. There are a number of programs that provide an evidence-base for effective abstinence-based programs that have delayed the initiation of sexual activity and even teenage pregnancy, including the mass-media program Not Me, Not Now, the Postponing Sexual Involvement program and the Reducing the Risk program. There is further evidence that the decline in teenage pregnancy between 1991 and 1995 was due primarily to increases in abstinence among young people and that this accounted for 39.3% of the decline.

205. It is notable that there has been a steady increase in a number of programs now described as 'abstinence-plus'. Many of these programs would previously have been described as 'comprehensive sex education programs' since they would have had content concerning both delay in sexual activity and contraception. However, there is a wide spectrum of 'abstinence-plus' programmes, some with considerably more emphasis on delay than others. With the evidence-base for the effectiveness of the abstinence-based approach coming out of the USA, the application of this approach in Scotland is crucial and should be incorporated into the Scottish Executive's forthcoming sexual health strategy. However, one caveat is that the utilisation of the 'abstinence-plus' label does not ensure that the programme places a large emphasis upon the benefits of delay and abstinence.

206. Uganda provides an example of the way in which the UN-led ABC approach can be effective in combating AIDS. Point A represents abstinence from sexual activity. If this does not happen then B is proposed which represents be faithful to one partner, known as 'zero-grazing'. Point C is for contraception if one fails to do A and B. The statistics show that the primary reason for Uganda's spectacular reduction in AIDS is primarily due to the adoption of B, be faithful to one partner. Abstinence was of limited effect because the problem was not so much one of the early initiation of sexual relationships, but rather prevalence of people having multiple sexual partners. Abstinence was effective among young non-sexually experienced girls. Condoms provided *'an additional muzzle on the virus'*, and were effectively used more recently among high-risk groups such as prostitutes. However, it should be noted that condoms were not in mass use before much of the decline had already been achieved in the late 1980s and early 1990s and hence their contribution to the Ugandan success was limited.

207. Uganda provides an example of a country which shows that behaviour change is possible. This change was achieved through a nationwide campaign that incorporated far more than just medical professionals. It

was also community based, involving religious organisations, political leaders and teachers in seeking to encourage safe behaviour utilising the ABC approach. The incorporation and collaboration of grass-roots organisations and faith communities into this national strategy, combined with the willingness of political leaders to provide support is an example that Uganda provides and from which lessons can be learned.

Part 2
Ethics

Chapter 4
The Discussion of Ethics in Sex Education

4.1 Introduction

208. This chapter considers the need to incorporate ethics into SRE and sexual health promotion. In defining ethics one is talking about the systematic study of moral choices. Underlying values are sets of principles that people use to determine what their behaviour should be. Ethics is the discussion and debate over these principles. It is putting under scrutiny the manner in which one thinks, what one believes and why. It is the failure to discuss the ethics of sexual relationships that can lead to teenagers 'just going along with the crowd'. Discussion and debate will encourage them to think for themselves, to hear other opinions, question their own, and be informed of the facts. The aim of the incorporation of ethics into SRE is the genuine informing of choice for the individual. This chapter also considers the human rights framework within which SRE and sexual health promotion are set, with a particular focus on the UN Convention on the Rights of the Child (UNCRC).

4.2 Why Ethics?

209. There are three broad points that need to be made regarding the importance of incorporating ethics into SRE. (1) The need for the promotion of **responsible behaviour** in young peoples' approach to sexual relationships. (2) The need to help young people **understand relationships** and ask the big questions such as 'what is a sexual relationship?' 'What is love?', the aim being to help young people develop their own understanding of what a sexual relationship is about. (3) To help teenagers recognise the various **messages and pressures** they receive from the environment about sex, therefore promoting genuine informed choice regarding sexual relationships.

210. (1) **Responsible Behaviour**. Bailey and Piercy in their paper '*Enhancing ethical decision making in sexuality and AIDS education*' provides some helpful introductory thoughts. They quote a story about a group of high school boys called the *'Spur Posse'* who were arrested on rape and assault charges. The boys were having a competition to see who could sleep with the most girls. They kept a running total of their conquests. *'They showed little respect for their female partners and did not seem to regret their actions. One member of the Posse said, "Everybody likes sex…I haven't done anything wrong." Another pointed out that this school teaches "safe sex" and gives out condoms, and that he used condoms "So," he asked, "what did I do wrong?"'*. Clearly this is a problem. As Bailey and Piercy go on to say: '*Condom use… is not a sufficient ethical yardstick, and more emphasis needs to be placed on the emotional, ethical, spiritual, and psychological dimensions of sexuality*' (Bailey and Piercy, 1997). This case study shows the need to ensure that SRE includes ethical discussions about how one will live. There is a need for a more thorough integration of the biological and the ethical in SRE. The kind of ethical dilemmas that the '*Spur Posse'* story raises include: the meaning of sexual relationships, the information they were given, coercion, and respect for others.

211. (2) **Understanding Relationships**. Sex is not a neutral, value-free activity without tremendous pleasure or consequences. A sexual relationship affects not only the individual but also the partner, family, friends and indeed wider society. Ethics involves asking questions and there is a great need to help young people ask

the more fundamental questions about sexual relationships including 'What is sex?', 'Why do they desire it?', 'What is a relationship?', 'What would they be expressing through sex?' and 'Why should they respect themselves and others?'. There needs to be a development onwards from the biologically focused approach to SRE in order to help teenagers consider the deeper questions that sexual relationships demand.

212. Too often people do not respect others and the result can be unethical behaviour, abuse, coercion, using others and feeling used. Young people need to be helped to think through the reasons why they should value others and respect them, and also the reasons why they should value themselves. Self-esteem certainly appears to be a problem among young people, including the strategies they use to gain a sense of their value (see Chapter 2, Section 2.3.6.). The emphasis of all these questions is to get beneath the superficial, to ask for example *why* one should respect others, not just that they should. If ethics is to be incorporated into sex education, time for adequate self-examination and questioning is essential.

213. (3) **Messages and Pressures**. An environment exists around teenagers today that communicates conflicting values about sexual relationships. Parents communicate one thing about sexual relationships, often the discouragement of activity, or even fail to discuss it at all. Many peers communicate another. It is often the reality, or indeed the perception - which is just as important, that the 'cool' students are sexually active and that it is generally normal to be sexually active. The notable exception to this label of acceptability are girls who are perceived as being *'easy'* (Mellanby et al., 1997). Pressure is communicated through the media which encourages sexual activity, for example boys' magazines tend to encourage sexual activity as *'conquests'*, and tend to treat girls as objects. Girls' magazines, generally include more helpful information about sex and relationships, but they do however presume teenagers to be either sexually active or that they will be in the near future (Batchelor & Kitzinger, 1999). In addition and as outlined above, adolescence is a period of identity formation that can sometimes involve the rejection, to some degree, of parental values (see Chapter 2, Section 2.4.2.), and it is understandable that peer pressure becomes an enormous influence as teenagers seek to gain approval and gain a position of identity within the wider society. The aim of ethics in SRE is to assist fully informed choice – helping young people to question their values and the principles that underlie them. Despite the conflicting and unrelenting messages that teenagers receive, many teenagers are very able to think for themselves. Ethics in SRE aims to help them in this process and extend the scrutiny that their own thinking, beliefs, and those of others come under in order to enable them in the formation of their own values and ethical principles for life.

4.3. An Ethical Approach to Sex and Relationships Education

214. To help in the process of considering the role of ethics in sex education, the following ethical framework, common in public health contexts, is used to guide thinking on the application of ethics to SRE. This framework will help in the analysis of where changes are needed to make sex education more ethically sound in its approach. Much like any other health decision, sex education should be about providing all the required information to young people to help them make their own informed decisions. In this respect the first important ethical principle that needs to be respected is the maintenance of a young person's *Self-determination*. There are four components to this. (1) The ability and competence of the young person to make their own decision (*Competence*). (2) The need for the young person to be provided with all the information they need to make an informed choice (*Information Provided*). (3) The ability of the person to understand this information (*Understanding*). And (4), the young person's ability to have freedom to make their choice (*Freedom of Choice*). The second important principle is *'Do No Harm'* the prevention of harm being done to a young person. Third, *Best Interest*, argues that is it not just harm that should be minimised but the very best interest of the young person promoted. Fourth, *Rights and Justice*, which focuses on the young persons rights and their need for fair treatment.

4.3.1 Self-Determination:

215. Self-determination is based on the ethical principle of respect for *autonomy*. It involves two elements: (1) The ability to examine the alternatives. (2) The person's capability to carry out the option they have decided on. The principle includes the idea of *informed consent*. Informed consent is a term commonly used in medical settings and is the knowledge of, and consent to, a particular form of intervention before it

is administered. In sex education this principle would reflect the fundamental choice whether or not the young person will have sex, hence the title of the report: *'Informing Choice'*. Autonomy certainly also includes issues relating to the young person's ability to make his or her own decision, the kind of information that is presented to young people, their ability to understand this information and their ability to follow this decision without undue pressure to choose a different course of action. Self-determination has four elements outlined below in sections 4.3.1.(a) – 4.3.1.(d).

4.3.1. (a) Competence:

216. Competence generally refers to a person's capacity for making a decision. As it is vital that the autonomy of an individual to decide for himself or herself is upheld, the competence of an individual to make such a decisions is therefore a crucial consideration.

217. The period of adolescence is one of remarkable change as the teenager shifts from childhood into adulthood. This process, according to Erikson, is characterised by the formation of identity, part of which often involves the rejection, to some extent, of parental and adult values. Erikson indicates that '*The adolescent mind is essentially a mind of the moratorium, a psychosocial stage between childhood and adulthood, and between the morality learned by the child, and the ethics to be developed by the adult'* (Erikson, 1965). According to Cohen, '*a delicate balance must be achieved between this rejection and the development of self-reliance and the internalization of self-selected ideals*' (Cohen, 1995). The kind of questions a teenager may be asking in this stage would be 'Who am I?' and 'Where am I going?'.

218. Regarding sex education, these changes during adolescence, both physical and psychological have important bearings on the young person's competence to make his or her own choices (see Chapter 2, Section 2.3.3). The literature does not establish whether or not 13 to 15 year-olds, for example, can make informed health choices. Indeed generalisations should be avoided. More research is certainly needed in this area. What can be said is that whatever the competence of the young person, there is no doubt that encouraging formal operational thinking[1] (see Chapter 2, Section 2.3.3.) in relation to sexual relationships, values and ethics would help teenagers to mature in their thinking about such issues. This cognitive development would enable greater forward planning, and hypothetical reasoning about situations of choice and risk they may face. Fulfilling all the ethical principles by providing all the information necessary and helping young people to think through this information in a way appropriate to their age and maturity is a crucial means by which cognitive development can be encouraged.

4.3.1. (b) Information Provided

219. This refers to the content of what a young person is told during SRE. It is based on the ethical principle of *disclosure*. All the information necessary in order for a young person to make an informed choice must be provided. This information could be categorised under two broad headings, (1) biological information and (2) psychological and relational information.

(a) Biological Information

220. Under the heading of biological information would come information on the biology and mechanics of sex, which has traditionally characterised sex education. Other issues, some of which may not always be addressed, include information on puberty and hormonal changes, pregnancy and sexually transmitted infections.

221. Teenagers need to understand their bodies and have the information that will empower them. As pointed out previously, the hormonal changes that a boy may experience can happen over a relatively short period

[1] The transition from concrete to formal operational thinking is marked by the following. Those who are concrete operational thinkers would be unable to recognize behaviour that place them at risk, whereas those who have developed formal operational thinking would be able to use hypothetical reasoning which would allow them to begin to reason beyond their immediate experience. The latter group would be able to hypothesize about the probability of risk that a certain behaviour (sexual activity) may incur. For those who are concrete operational thinkers they would be unable to potentially hypothesize in such a way (Biro and Rosenthal, 1992).

of time (see Chapter 2, Section 2.2.1.). For girls the pubertal changes are slower and more gradual, but nevertheless are a similarly significant change. Additionally, girls need to understand the changes that can occur during their monthly cycles, with a usually heightened sex drive and emotional changes at certain times. It is vital to prepare young people for these changes. They will need to understand what is happening so that they can cope better with the physical and emotional changes.

222. STIs are a major and growing problem among young people, sometimes resulting in tragic consequences. One area where young people need more information to help them make informed decisions are figures on the effectiveness of condoms in the prevention of STIs. The effectiveness of condoms can only be presented in terms of scientifically verifiable laboratory tests of condoms and their effectiveness against STIs. The Physicians Consortium responding to claims from the Centre for Disease Control in the USA makes the point that '*Quality control must not be confused with protectiveness against STI's in the real world. Sex is an act of human passion, and as such pays little regard to theoretical models and mechanical testing under ideal conditions*.'(The Physicians Consortium. 2002). The limitations of condoms to protect against HPV was noted earlier in Section 1.2.2. The growing emphasis on intentions and self-efficacy in condom use is useful in trying to help young people use condoms appropriately. However, realism on the scientific effectiveness of condoms against STIs in the context of emotionally charged atmospheres, where mistakes can and often do happen, needs to be acknowledged to young people to allow for the full and accurate sharing of information on this important issue. Care needs to be taken that condoms are not described as making sex 'safe', only that they can make sex 'safer'. There is a false impression given by using the word 'safe' in the context of sex education. The teenager can be led to believe that condoms are the absolute answer to sexual health risks, when in reality they will only make sex 'safer'- this is being increasingly acknowledged.

223. The fear that this type of information would discourage the use of condoms should not be used as a basis to deny young people such information. The ethical principle of seeking to provide all the information necessary should not be undermined through fear of the consequences of potential non-use of condoms if their limitations are presented. The need to fulfil the ethical principle of full information disclosure demands that one should trust the consequences to young people and allow them to make their own health choices. Clear presentation of condom effectiveness would still be the basis for encouraging use for those who are choosing to be sexually active, but may also be the basis of some choosing to delay sexual activity or limit their number of partners. Such information is vital to create genuine informed choice.

(b) Psychological Information

224. Information about relationships in sex education is essential. This is perhaps the area where the present approach to sex education is weakest. An appropriate explanation of what is happening in a sexual relationship between two people is required. Is it purely a physical act with pleasure? Why do they desire sex? What are they expressing through sex? Is it commitment, desire, physical closeness, or the giving of oneself to another with the feeling of mutual belonging? If it is giving of oneself to another, then does this explain why some people feel used after sex? The incidence of regret among young people after sexual intercourse is well documented (Wight et al., 2000) and is being, and needs to continue to be, presented to young people. These are fundamental questions for young people to understand and consider. Such information is needed in order to help them make informed choices regarding sexual relationships.

The Relational Context

225. As to the question 'What is sex?' – what do young people think sex is about? Is it a purely physical act, or is it more fundamentally a relationship? Young people need to be helped to think through why they would have sex, and what they would be expressing through sex. As stated earlier this may be, for example, physical desire or love. If love, what do teenagers mean by this? Self-giving, commitment, physical attraction? The deeper questions need to be asked, to allow teenagers to think through why they are attracted, why they would have sex, and what they would be doing by having sex? As Franz states in his paper: *'Sex is a relationship, and a decision to give of oneself. An adolescent may not fully understand these concepts but he or she can be helped to value them.'* (quoted in Bailey and Piercy, 1997). If sex is a giving of oneself, then does this explain why some people value virginity and wait for that special person?

Such questioning would develop and assist thinking and avoid young people just walking into sexual relationships in an uncritical manner.

226. On top of this could come discussions of 'What is love?' What do young people think love is about. How does one know if it is true love or not? In one recent study it was shown that only 15% of young men in the UK cite love as the reason for first sexual intercourse, whereas for young men in the Netherlands the figure was over half (HEBS, 2002). The need to help young people think through this most central question is vital. The figure quoted merely emphasises the greater maturity that is evident among young men in the Netherlands in their grasp of the relational context of sex. Discussing questions such as 'What is sex?' and 'What is love?' will help young people build a sense of understanding of sex in a context of relationships. Asking such questions should naturally lead onto a consideration of relationships, to help young people think through what they want from relationships, what they value, and help them build goals for future relationships. The relational context is absolutely vital and helping young people to think through what makes a good relationship is essential.

Non-sexual needs

227. Much of what was outlined above would be relevant in determining what young people are expressing through sex. Also significant is the issue of sexual expression being about the fulfilling of non-sexual needs (see Chapter 2, Section 2.3.1.). Indeed, it is suggested that a lot of sexual activity is about satisfying non-sexual needs such as the need for affection, to ease loneliness, to be loved or to confirm masculinity or femininity. It was proposed that these non-sexual needs artificially inflated the sex drive, and because they were often unsatisfied through sex, these multiple needs were often fused into one, and are expressed through an inflated sex drive. Adolescent psychologist David Elkind points out that '*Contrary to popular opinion, most young people engage in sexual activity for psychological rather than hormonal reasons*' (quoted in Campbell-Rate A, Kids and Condoms). Indeed, it is fair to say that most people who have sex are seeking to meet non-sexual needs through it. The aim is to help young people to recognise these needs, and, if necessary, seek alternative ways of fulfilling these needs. Young people need to be helped to develop skills of introspection and questioning. It is vital that young people are helped to recognise the non-sexual needs that they are seeking to meet through sexual intercourse and for young people to consider, if necessary, how they could meet these needs in other potentially less damaging ways.

Respect

228. There is often little consideration as to why young people should respect themselves. Young people often struggle to accept themselves and accept their own value. They desperately need to be taught about their intrinsic value as individuals, that they are special and unique and have value and dignity regardless of their abilities or achievements. Respect is often seen in terms of the individual and building self-esteem. However it also brings with it an application to the relational context, the need to help young people consider others and their needs, to value them and respect their rights. Young people need help to consider more deeply why they should respect themselves and others.

(c) General Issues

229. Some other issues are relevant to the ethical principle of providing all the information necessary in sex education to allow for informed decision-making. In sex education theory there is a growing sense of the inadequacy of information to change behaviour, hence, the adoption of social psychological theory into sex education. This includes self-efficacy which seeks to give teenagers the skills to use condoms well or the skills to say 'no' to sexual pressure and therefore help young people to anticipate how they will act before a situation arises. This is seen as crucial to effecting behaviour change. The danger with the adoption of such approaches is that information is not perceived as a priority and is therefore held back because it is not seen to effect behaviour change in young people. It is therefore vital that while there is recognition of the limitations of information provision to affect behaviour change in young people who are, or soon will be, sexually active, that information should nevertheless be presented in its entirety. As already outlined, the inability of some young people to take in information and have it affect behaviour may be due to the young person still operating at more immature modes of thinking (see Chapter 2, Section 2.3.3.). This would make them unable to use information and apply it to hypothetical situations of sexual pressure, thus

making information provision inadequate. Indeed, as mentioned under the discussion of competence, generalisations about the ability of young people to use information should be avoided. Regardless of the level of competence, the ethical principle of providing appropriate information should be fulfilled.

230. Also important is that information provision to young people is in an age appropriate way. For example, that they are not taught about puberty years before its onset, or about contraception use well before the possibility of sexual intercourse. Debate is needed on these issues. Information should be presented in a manner appropriate to their cognitive capabilities.

4.3.1. (c) Understanding:

231. Understanding is based on the ethical principle of *comprehension* and relates to the extent of understanding the young person has of the information that is provided. The ability of a teenager to understand will, in one sense, be determined by their competence (see section 4.3.1.(a)). As stated in the information section (4.3.1.(b)), perhaps the most important thing for young people is for them to understand what a sexual relationship is and what they would be expressing through sex. They need to understand the biological, psychological and relational issues in order to think through these questions.

232. Young people need to be helped to understand the reality that sex is never isolated from the wider society, that it can be pleasurable, but it can also lead to hurt and rejection. Sex inevitably changes and affects a relationship permanently and the issues of how sex can change the dynamics of a relationship need to be explored. Moreover, the consequences of sex are not just relational, but can also be in terms of possible STIs and pregnancy, the consequences of which are vital for young people to understand. In addition, as outlined in Section 4.3.1.(b) the risk of STIs, with and without protection, needs to be clearly understood by young people to help them in their decision-making.

4.3.1. (d) Freedom of Choice:

233. Freedom of choice is the ability to make a choice without being unduly pressured to choose another course of action. There are a number of important areas in the application of this ethical principle to SRE.

234. First, and perhaps most importantly, the values framework in which SRE is taught should not be biased towards one moral perspective. The teaching of SRE should allow for the various ideologies about sexual relationships to be presented and discussed. Some SRE programmes have sought to be value-neutral in approach but these may fall into the trap of being rooted essentially in a relative and subjective moral framework. This may communicate to young people that there is no absolute moral framework or a right or wrong way to live. Indeed the Scottish Executive's draft sexual health strategy states "*it is not appropriate to arbitrate on sexual matters*" (Scottish Executive, 2003). However, arguably the Scottish Executive should develop an evidenced based strategy. Where this points to the sexual health benefits and negative consequences of specific behaviour this should be explicitly stated. The proponents of the various ideological positions are unlikely to agree as to what values should underpin SRE. However, it is precisely because of this disagreement that the Scottish Executive should seek to be both ethical and evidenced-based in its approach.

235. Sex education that maintains freedom of choice should be promoted. Respecting the freedom of conscience and religion is paramount. Sex education should be explicit in its value base, communicated clearly to parents, and their agreement sought.

236. Peer and media pressure is another crucial area that needs to be addressed. The influence on teenagers from both peers and the media is indisputable. To maintain the principle of '*freedom of choice'* in sex education, there needs to be an 'exposing' of these pressures, their manifestations, and the dynamics that make them effective in the life of a teenager. This would include the desire for acceptance and the setting of peer norms and trends that induce pressure and the communication of what is 'normal' behaviour. Among many teenagers there is a perception that the majority of peers have had sexual intercourse. Such perceptions can clearly be compared with the reality. These pressures have been outlined in Chapter 2,

Sections 2.5.1 and 2.5.2. It is vital that the 'freedom of choice' in the young person's decisions about sexual relationships is maintained as he or she understands the dynamics of the pressure he or she is feeling.

237. Also relevant to the principle of 'freedom of choice' is the issue of coercion (see Section 2.3.5.). All coercion towards sexual activity is harmful to a young person's freedom to choose. For example, the definition of rape is much broader than simply *'a stranger jumping out from behind a bush'* (Lamb, 1997) and there is a need to develop a definition of consensual and non-consensual sexual activity. Also relevant is the problem of bullying, both the well documented homophobic bullying and of those who are, for example, still virgins.

4.3.2. Do No Harm:

238. The ethical principle of doing no harm is recognised as one of the most traditional ethical principles. It could include the prevention of harm, the removal of harm when present, and not inflicting harm on another person.

Physical Harm

239. Traditionally, this ethical principle has been the basis of sex education since the rise of the AIDS pandemic in the mid 1980s. The 'do no harm' principle has been the foundation of the safer sex, harm minimisation approach to sex education.

240. The physical harm-minimisation approach has steadily increased in influence among sexual health professionals in recent years. It could be defined as an approach that seeks to be non-discriminatory and accepting of the reality of teenage sexual activity and therefore does not seek to deter these activities per-se, but rather is an approach that seeks to reduce the adverse consequences of these activities. It borrows the approach from drugs strategy. It seeks to reduce the physical harm of behaviour, be it drug use or sexual activity. However, one criticism is that the approach can tend to be in danger of condoning the risk activity itself. When the harm-minimisation approach is used among teenagers, it can be seen as encouraging underage sexual activity. The approach is popular in sexual health because it is seen to be non-discriminatory to those who are sexually active and realistic about the reality of teenagers having sex. However, it is a one-size-fits-all approach that faces the issues as if all are, or soon will be sexually active, thus leaving those who are going to delay sexual activity in danger of feeling pressurised into sex. It also does not address the more underlying reasons for sexual activity.

241. Harm-minimisation is an approach that seeks to reduce physical harm amongst those most at risk. The problem is the degree to which this approach is central or not, and whether it is the primary method, thus incurring the problems noted above, or whether it will be a secondary approach behind a more preventative promotion of the young person's 'Best Interest'. Making harm-minimisation secondary to a more preventative 'Best Interest' approach, such as encouraging delay in sexual activity (see Section 4.3.3.), will alleviate some of the negative consequences of promoting harm-minimisation as the primary method and ensure a balance in the information young people recieve.

Psychological harm

242. There also is a need to get beyond the application of this ethical principle to the physical health of the individual (AIDs, STIs and Pregnancy). The definition of 'harm' is broad. It includes psychological or emotional harm through, for example, regret of an early sexual experience, coercion and rejection. On this basis there should, at the very least, be an encouragement to help young people make wise choices in how they will live to prevent such harm.

4.3.3. Best Interest:

243. The best interest principle is the positive dimension of 'do no harm', in other words we can see these two principles on a continuum with 'do no harm' at one end and best interest at the other. 'Best interest' challenges that not only is no harm done, but positively moving up the continuum, the very 'best interest' of the young person regarding sexual relationships is promoted. Best interest means that SRE should contribute to the student's welfare. A teacher should therefore present the benefits and the dangers of the various choices a young person may make with best interest being clearly presented. Best Interest is one of the main principles guiding, for example, the UN Convention on the Rights of the Child – based on Article 3 of the Convention (see Section 4.3.4.).

244. Best interest is often not considered at all or interpreted as being solely defined by the individual. There is no guide therefore to what the best interest may be for the young person. This paper, however, argues that best interest should be determined by evidence-based research. For example, the young person's best interest may be determined by looking at the results from evidence-based research into the effects of teenage sexual activity on the young person, and the risks associated with it. The evidence-based approach is acknowledged as an important ingredient to progress in sexual health.

245. Early sexual activity, especially among those who initiate sex under 16 years-old, is associated with poor contraceptive use, increased risk behaviour, more sexual partners during a lifetime, sex starting earlier in relationships and a greater likelihood of psychological harm and regret (Mellanby et al., 1995). Age at initiation of sexual activity is correlated negatively with higher pregnancy and increased STIs (Kotchick, 2001). In one study STIs were reported by 13% of men who initiated sexual activity before 16 and by 6% who initiated sexual activity later. For girls the corresponding figures were 28% and 12% (Dickson et al., 1998). The effects of early initiation endure into later life, with a number of studies showing that younger individuals are more likely to have lower sexual knowledge, and unhealthy sexual behaviours than later initiating peers (Beitz et al, 1998; White and DeBlassie, 1992).

246. As already outlined (see Section 4.3.2.), the principle of 'do no harm' (physically) has probably been regarded as the foundation of the approach to sex education since the AIDS epidemic in the mid 1980s. This approach of physical harm minimisation has seen the promotion of safety in sexual relationships through the use of condoms. However, there is a conflict of interest between this 'do no harm' and what may be the 'best interest' of the individual. For example, physical harm is still possible, even with the use of contraception (see section 4.3.1.(a)). The figures given in the paragraph above argue that the detrimental consequences of early sexual activity can be reduced by encouraging young people to delay until they are older. Further, questions over competence may argue for the encouragement of delay until the young person is older and more able to make their own decisions.

247. One of the dangers of promoting 'best interest' is that of paternalism. One may be able to say with a fair degree of confidence what is in the best interest of the young person, but will that person's freedom of choice be overridden so that best interest is fulfilled? The key to promoting best interest is clearly presenting the benefits and harms of various choices and making it clear what would be in the young person's best interest. However, this should be done in such a way that the young person maintains their freedom of choice as to how they will live their lives. Importantly, the desire to maintain autonomy does not, as stated earlier (Section 4.3.1.(b)), require the holding back of information about what may be in the best interest of the young person. Emphasising that delay may be in the 'best interest' of the young person remains important and would provide a balance of information compared to the current emphasis on harm-minimisation approaches.

248. Ethics requires the full informing of young people with the information they need. If SRE is to be ethical, best interest needs to be clearly presented to young people. This will be achieved through young people having all the information they need concerning their best interest, that they understand this information, and that it is presented in a way that is appropriate to the young person's age, maturity and competence. Communicating best interest according to the facts is not being paternalistic. Enforcing best interest is.

4.3.4 Ethics and Human Rights

249. The modern human rights movement arose in the aftermath of World War II. The founding document was the Universal Declaration of Human Rights which was adopted and proclaimed by the UN General Assembly in Resolution 217A (III) on 10 December 1948. Since then a number of further human rights documents have been drawn up. These include the European Convention on Human Rights (ECHR), the UN Convention on the Rights of the Child (General Assembly Resolution 44/25, Nov 1989) and the European Convention on Human Rights and Biomedicine (European Treaty Series – No.164), although the UK Government is still to ratify the latter. Ethical principles underpin these conventions that include the idea of fairness, the prevention of discrimination and respecting people's intrinsic rights.

250. In developing approaches for SRE and sexual health promotion the above conventions contain a number of relevant rights and statements. The Universal Declaration of Human Rights proclaimed '*that childhood is entitled to special care and assistance* and that the family is *the fundamental group of society and the natural environment for the growth and wellbeing of all its members and particularly children.'*

251. Article 2 of the First Protocol of the ECHR establishes '*a right to education* and further details that this must be in accordance with the *religious and philosophical convictions of parents*'. The ECHR was incorporated in Scottish law by the Human Rights Act, 1998 and the right to education is also reflected in the Education (Scotland) Act 1980. Moreover, the Scotland Act 1998 requires that all legislation passed by the Scottish Parliament is compliant with the European Convention on Human Rights.

252. The UN Convention on the Rights of the Child (UNCRC) is the main framework for incorporating rights into the lives of children and young people (see Appendix 2). The principles that underline the Convention have been identified (UN Committee on the Rights of the Child, 2002). These are:

- *Non-discrimination* - the child should enjoy their rights regardless of colour, race, sex, language, religion or disability.

- *Best interests* - these shall be promoted at all times.

- *Survival and development* - including physical health and emotional, cognitive and social development of the child.

- *Participation* - children have the right to express their views, where they are capable, and to have them heard.

253. The UNCRC is the convention with most direct relevance to SRE and sexual health promotion among young people. The Convention is based on the ethical principles outlined in this chapter and it provides a legal framework for the application of these principles in relation to children. Arguably, therefore, the existence of the UNCRC supports the incorporation of ethics into sex education. The articles of most direct relevance are Articles 1, 3, 12, 13, 14, 17, 18, 24 and 28.

- Article 1 applies the Convention to all children under the age of 18.
- Article 3 establishes that in all decisions relating to children their '*best interests'* should be the '*primary consideration.*'
- Article 12 of the Convention requires that the views of a child be '*given due weight in accordance with the age and maturity of the child.'*
- Article 13 establishes that a child has a '*right to freedom of expression'* which includes '*freedom to seek, receive and impart information.*'
- Article 14 recognises the '*freedom of thought, conscience and religion'* of the child and obliges States to '*respect the rights and duties of parents… to provide direction to the child … in a manner consistent with the evolving capacities of the child*.'
- Article 17 recognises the '*important function performed by the mass media*' in providing information to the child and establishes the right of the child to access information sources, '*especially those*

aimed at his or her social, spiritual and moral well-being and physical and mental health.' It also requires guidelines to be applied to protect the child from '*information and material injurious to his or her well-being'* and applies this specifically within the context of Articles 13 and 18.

- Article 18 recognises the principle that parents have *'the primary responsibility for the upbringing and development of the child'* and that '*best interests'* are their basic concern.
- Article 24 recognises the right of the child to '*the highest attainable standard of health'* and obliges States '*to ensure that no child is denied his or her right of access to such health care'* services.
- Article 28 of the UNCRC establishes '*the right of the child to education*.'

254. These principles and rights confirm all the ethical principles outlined in this chapter, including seeking the 'best interest' of the child at all times, maintaining the child's freedom of choice over his or her own life in proportion to their competence to do so, and establishing the principle of 'doing no harm' to the child. Further emphasised is the right of the child to health, freedom of conscience, religion and thought, the vital role of parents, and the need for the media to be responsible in their approach to young people.

255. The emphasis on the need for children to have their rights respected is in one sense admirable. However, this should not be seen purely in terms of personal autonomy, but rather in terms of corporate responsibility. Indeed to interpret the UNCRC purely in terms of personal autonomy arguably undermines access to the very rights contained in it. For example, freedom of expression might be interpreted to allow a young person to express 'love' through engaging in sexual intercourse without making any moral judgement about this activity. However, if a young person catches or spreads an STI their, and their partner's, right to health and 'best interest' has been undermined. Similarly, it might be claimed that children have a right to access information on contraception and to access sexual health services. However, if access to this information and/or these services is prioritised at the expense of encouraging delay in the onset of sexual activity, arguably the right of the child or young person to have their best interest taken into consideration has been compromised. The emphasis on rights in the debate over sexual health needs to be accompanied by an emphasis on the responsibility to care for others and to respect their rights.

256. A common interpretation of the UNCRC in regard to sexual health is that young people have a right to sexual health, including access to the full range of sexual health services and the information and skills necessary to ensure that this right is fulfilled. However, this is only one perspective on the implications of the UNCRC for SRE and sexual health promotion. Other implications are also immediately evident from consideration of the UNCRC. First, in accordance with Article 3, the ethical principle of '*best interest'* should be promoted as the primary focus of SRE and sexual health programs. Second, the spirit of Articles 13 and 14 suggests that young people should not be pressurised into a particular course of action. Third, Article 17 provides a challenge to the media in its output and should be the basis of all advocacy work with the media. Fourth, the primary role of parents in the upbringing and development of children should be recognised. Furthermore, the stage of cognitive development of the child or young person must also be considered and arguably parents are best placed to make this assessment. Article 6 of the European Convention of Human Rights and Biomedicine states in relation to health care that the opinion of a child or young person should be '*taken into consideration as an increasing determining factor in proportion to his or her age and degree of maturity*.'

257. In addition, a balance must be struck between the rights of the child and parental rights in relation to SRE and sexual health promotion. Articles 5 and 18 of the Convention recognise the rights and responsibility of parents. Parents are established as providing guidance, and having primary responsibility for the upbringing and development of their child. The convention expects that parents will act in the best interest of their child. Article 14 of the Convention recognises the role of parents in giving direction to their child in relation to the child's rights to freedom of thought, conscience and religion, and requires State parties to respect the rights and responsibilities of parents in this regard. Arguably, therefore, the provision of information on contraception and access to sexual health services by State authorities against the will (and possibly without the knowledge) of parents may breech these articles.

4.4 Conclusion

258. Ethical language is used throughout sexual health settings but rarely with any full application of these principles. The ethical principles provide a framework that, when applied to SRE and wider sexual health settings, will promote genuine informed choice among young people about sexual relationships. Such ethical principles are used throughout other public health settings to ensure informed choice and should be fully applied to sexual health. The benefits of incorporating ethics will be the full provision of information to young people and promotion of responsible behaviour as young people consider the importance of respect and value both for themselves and for others. With regard to biological information much work has already been done in SRE programs, however there is still a lack of information on, for example, the scientific effectiveness of condoms and their user-failure rates. Regarding psychological and relational information, much work is required in order to promote informed choice including helping young people understand how sex may be used to fulfil non-sexual needs such as the desire to ease loneliness or bolster self-esteem. Young people also need to understand what sex is, and that it is much more than a purely pleasurable physical act. For example, that it is a relationship reflected in a giving of oneself to another, as evidenced by high levels of regret after an early sexual experience or strong feelings of rejection. Further, young people need to be helped to think through what love is and what it may be characterised by. All this should lead to helping young people build goals for what they want from future relationships all for the purpose of promoting informed choice among young people.

259. In providing information to young people, age and cognitive ability should be taken into consideration. Some young people are not able to anticipate risk relating to sexual activity. Information provision to young people should therefore be qualified by such considerations and not provided too young or well before puberty. This has implications for the ethical principle of promoting freedom of choice, although the choice should always remain with the young person. Provision of information should be qualified by the competence of the young person to make informed decisions. In other words, information should not be supplied to young people regardless of age and cognitive development. Another issue that impacts on the young person's freedom of choice is peer pressure, which needs to be better utilised in order to correct false impressions that *'everyone is having sex'*. Media messages are also seen as giving the impression that young people are, or soon will be, sexually active. Critical viewing of media portrayals of sexual relationships should be promoted as should the encouragement of honest media messages including the consequences of sex and encouraging positive role models for such things as delay in sexual activity. Addressing these two factors should help promote genuine freedom of choice.

260. Other key ethical principles that need to be considered include the principle of 'do no harm' which is the basis of the harm-minimisation approach to sexual health that seeks to be non-discriminatory and accepting of sexual activity among young people. Therefore, the approach seeks, through the use of contraceptive services, to minimise the possible physical harm associated with sexual activity. Harm-minimisation is inadequate when used as the primary approach to sexual health for it tends to be one-size-fits-all and does not distinguish between those are who are, or soon will be, sexually active and those who will not. Harm-minimisation needs therefore to be balanced by an explicit promotion of the very best interests of the young person. Best interest is the encouragement of delay among young people due to the increase risk associated with early sexual activity. It also raises questions over the competence of some young people to make informed choices. Making sure young people understand as much of the information and relational aspects of sexual activity before sexual activity is commenced should be a priority of SRE. The benefits of delaying sexual activity until the young person is older should be clearly presented as a priority measure in promoting best interest. Balancing the harm-minimisation approach with the explicit encouragement of delay should promote genuine informed choice among young people.

261. The United Nations Convention on the Rights of the Child is based on the ethical principles outlined in this chapter. This also applies to the other conventions cited in this chapter. It is important, therefore, that all the ethical principles outlined are applied in relation to SRE and sexual health promotion in order to ensure that rights are balanced by responsible behaviour. Sex is rooted in relationships with both positive aspects and also risks and consequences. Rights do clash, but the promotion of ethics can temper the excesses that may arise in the interpretation of the Convention and can encourage responsible behaviour towards others

while respecting their rights. In applying the UNCRC (and other human rights conventions) to SRE and sexual health promotion, the Scottish Executive and local authorities should consider the need for a wide application of the Convention's principles and rights, including perhaps most importantly the promotion of the very 'best interests' of the child and the provision of information appropriate to each child's age and stage of cognitive development. Moreover, the rights of parents should be respected as they are the people having the primary responsibility for the upbringing and education of their children.

Chapter 5 Conclusion and Recommendations: Some Collaborative and Ethical Approaches to SRE and Sexual Health Promotion

262. If the Scottish Executive wishes to improve sexual health in Scotland it must seek to find common ground to underpin its forthcoming strategy. With Scotland's recent history of polarisation over SRE it is important to identify areas of consensus and to base interventions and policies on a sound evidence base. Such interventions and policies should also be based on the full range of ethical principles. Failure to do so will result in a strategy which is unlikely to be based on consensus and ultimately may have little realistic prospect of changing behaviour and hence improving sexual health.

5.1 Ethics: A Collaborative Goal

263. This report has focused on the need to incorporate ethics into SRE, and wider sexual health settings. Sex education and sexual health has loosely applied various ethical principles, even using ethical language such as *informed choice, do no harm, best interest* and *rights*, but there has been little or no application of these principles. Ethics provides a context for making decisions that respects the person's rights and promotes his or her freedom to choose by providing all the necessary information to allow a person to make informed decisions about sex and relationships. Young people in particular should be given all the relevant information about sex and relationships in order to allow them to make their own informed choices, and this will only be achieved through the incorporation of ethical principles into SRE. It is essential that SRE and sexual health promotion conforms to such principles. Not applying the ethical principles outlined in Chapter 4 is not an option that should be considered, for it denies young people their needs and rights to make fully informed choices. It should be the basis of all education and services and should be fully outworked as this paper has highlighted. However, this right is qualified by the stage of cognitive development of the child and the need to respect the rights of parents in their role of promoting their child's best interests and therefore to determine their access to appropriate information.

264. Incorporating ethical principles should broaden people's understanding of sexual relationships and promote responsible behaviour while respecting one's own and other people's rights and dignity. This reflects current statutory guidance contained in Circular 2/2001 on the teaching of SRE, which was issued under the Standards in Scotland's Schools Act 2000 (see Chapter 1, Section 1.5.3 (b)). Accordingly, it should be based on '*sound values'* and taught in a way that encourages responsible behaviour and a recognition of the need for self-restraint. The circular also calls on the content of SRE to promote the respect and dignity that should be afforded to the young people themselves and to others. Applying such ethical principles to SRE

should prevent coercion in sexual relationships and the abusing of other people's rights, which can lead to sexual abuse.

265. Full incorporation of all the ethical principles outlined is an important collaborative goal for SRE and sexual health promotion. This approach would build trust between parents, professionals and young people, which existing approaches have largely failed to do.

266. It is important to highlight that there are debates over the application of some of the ethical principles outlined in Chapter 4 to SRE and wider sexual health promotion. These debates are related to the following ethical principles

(1) The ethical principle of ensuring full information provision to promote genuine informed choice.
(2) The principle of freedom of choice.
(3) The principle of 'do no harm' and the questions surrounding the application of a harm-minimisation approach to sexual health.
(4) The principle of 'best interest' and the need to promote it.
(5) The principle of rights and the issues surrounding a rights-based approach to sexual health.

RECOMMENDATIONS

- **The incorporation of all the ethical principles outlined in Chapter 4 into SRE should be encouraged by the Scottish Executive as of first priority in order to promote responsible behaviour based on sound principles and fully informed choice amongst young people.**

- **The Scottish Executive should take into account the ability of individual young people to make competent decisions about sexual relationships at different ages and stages of cognitive development.**

5.1.1 Full Information Provision

267. To allow for informed choice the relevant information should be provided. Without all the necessary information being presented, SRE will fail to be ethical in its promotion of genuine informed choice. Information provision is therefore a vital area for consideration in SRE.

268. Much work has been done on the biological side with information about STIs, pregnancy and puberty being common in sex education material. It is established that young people do not only need to be informed of the positive sides of sexual relationships, but also of the physical risks and consequences associated with them. However, it must be ensured that young people are given all the information possible concerning STIs and the risk of pregnancy. For example, it is vital that young people be told about the scientific effectiveness of condoms in their protection against STIs, and also of user-failure rates. Sadly, many young people can leave a classroom with the impression that condoms will make sex *'safe'*, when in reality it will only make sex *'safer'* against STIs, and in the case of Human Papillomavirus offers virtually no protection (see Section 1.2.2.). Young people need this information in order to be able to make an informed choice about sexual relationships. The purpose here is not to call into question the usefulness of condoms in making sex safer, but merely to promote the importance of giving young people all the information they need in order to make informed choices.

269. With regard to the psychological and relational information associated with sexual relationships, this is an area where the least work has been undertaken in SRE. Sex education tends to focus on the biological issues often to the expense of the psychological and relational aspects of sexual activity. Young people need to be helped to understand fundamental questions about sexual relationships including:

270. ***What is Sex?*:** One of the most important areas for sex education that should be developed concerns the understanding of sex. It should include not just information on physical pleasure, but also relationships. Young people need to be informed about what they are really doing through sex. For example, if it is giving of oneself to another, then does this explain why some teenagers can feel regret after sex? Does this also explain why people often feel rejected and hurt after the breakdown of a sexual relationship?

271. ***What is Love?*:** It is important for young people to consider what they understand behind a term such as love. What does falling in love mean? What does it feel like? This is an area which even adults find difficult to comprehend. Therefore, it can only be expected that young people will be even more perplexed and confused by their feelings and thoughts relating to love. This can only serve to undermine their capacity to make an informed choice if these issues are not sufficiently clarified. The limited consideration of 'love' in the Scottish Executive's draft sexual health strategy is surprising considering the fact that 'love' is central to the language of young people with regard to adolescent relationships whether it is sexual or not. Does being in love only mean an emotional feeling, or does it also represent a deeper commitment to and respect for the other person?

272. ***What is important in Relationships?:*** Young people can be helped to consider what they value in a present or future relationship. Considering questions such as those above can help young people obtain the information they need to develop goals and informed choices about what they want from any future relationships. To consider the kind of person with whom they want to develop a relationship. The need for commitment and the building of longer-term relationships are issues that young people can be helped to think through and consider. Indeed these points should be included in sex education material according to Circular 2/2001 on the Standards in Scottish Schools etc. Act (2000) (see Chapter 1, Section 1.5.3 (b)).

273. ***Non-sexual Needs:*** Young people, as outlined in Chapter 4, and more fully in Chapter 2, Section 2.2.1., often use sex to fulfil non-sexual needs such as affection, to ease loneliness, bolster self-esteem or to confirm masculinity or femininity. Young people desperately need to be helped to understand these motivations. This will help provide greater self-understanding and therefore more autonomy in informing their choice concerning sexual activity.

274. ***Respect:*** The language of respect is in use throughout sexual health. Respect is often seen in terms of having respect for oneself and respect for others and their rights. Young people are exhorted to respect but they need to be helped to understand why one should have respect for themselves and others. Without helping young people to understand these issues, exhortations to respect are unlikely to be effective. Young people need information and understanding about their intrinsic value, that they are special and unique individuals regardless of achievements or abilities and that other people are special aswell. Such information is closely tied to self-esteem and human dignity and has implications for behaviour in relationships.

RECOMMENDATIONS

- **In the provision of biological information, the Scottish Executive should ensure that information is given on the scientific effectiveness of condoms in preventing STIs, in addition to user-failure rates, to ensure that informed choice is promoted. Particular reference should be made to HPV and the fact that condoms offer very little protection against this particular STI.**

- **Sex and relationships education should seek to help young people consider what sex is within the context of love and relationships as required by the Scottish Executive Education Department Circular 2/2001.**

- **The Scottish Executive's forthcoming sexual health strategy should ensure that young people are aware that sex is often used to fulfil non-sexual needs and that alternatives exist which may address these needs.**

- **The Scottish Executive should ensure that schools provide information concerning sexual relationships that is understandable to the young person and appropriate to their age and stage of cognitive development.**

5.1.2 Freedom of Choice

275. As outlined in Chapter 4 (see Section 4.3.4), Articles 13 and 14 of the UN Convention on the Rights of the Child recognise the freedom of expression, in addition to the freedom of thought, conscience and religion of the child or young person. Clear behavioural guides are seen as being crucial for effective sex education programs (see Chapter 3, Section 3.3), and the principles for teaching of sex education are that it should be taught in a context of *'sound values'* in accordance with Circular 2/2001. The need nevertheless to avoid coercion and to always leave the final decision to the young person is paramount if this ethical principle and right is to be fulfilled, although this must be considered with reference to the competence of young people to make informed choices and the age appropriateness of information (see Section 5.1.4).

276. Relevant to the issue of freedom of choice is the issue of the media influence on young people. There is a growing awareness of the influence of the media in relation to young people's sexual activity (see Chapter 2, Section 2.5.2.). Hence, the recognition of the importance of the media in the Scottish Executive's draft sexual health strategy is welcome. The draft Strategy outlines the need to respond to the media to support programmes aimed at improving sexual health. One of the problems acknowledged is the portrayal of sexual relationships within the media, the messages that are communicated, and the pressure they exert on young people.

277. It is crucial that the media be encouraged to have positive role models in relationships that will challenge the message that *'everyone is having sex'*, and give confidence to those who feel the pressure to be sexually active. Evidence from the USA points to the important role of the media in combating teenage sexual activity. One US program that proved successful in achieving culture change is the Not Me, Not Now mass-media campaign in Monroe County, New York (see Chapter 3, Section 3.3). Such examples should be seriously considered for application to Scotland and inclusion in the Scottish Executive's forthcoming sexual health strategy. Moreover, Article 17 of the UNCRC requires States to ensure that in accessing information via the media the child's *'social, spiritual and moral wellbeing and physical and mental health'* is protected. It also requires States to encourage the media '*to disseminate information of social and cultural benefit to the child*.' The Scottish Executive should ensure that any media campaign arising from the forthcoming sexual health strategy is consistent with its obligation under the Convention.

278. Peer pressure is also a critical issue relating to freedom of choice. The influence of peers on young people cannot be underestimated. Young teenagers mention pressure from partners or friends as the main reason for sexual intercourse (see Chapter 2, Section 2.5.1.). The influence of peers may prove to be the greatest single factor in encouraging the onset of sexual activity. Culture change amongst teenagers and delay of sexual activity are vital if sexual health is to improve and the unwanted teenage pregnancy rate is to decline. To achieve this, a number of key preventative measures are needed. In order to reduce the influence of negative peer pressure that can lead to the encouragement of early and risky sexual activity, there needs to be an increasing level of connectedness between young people and both schools and parents. Research from the Netherlands appears to show the continuing importance of the family unit in that country and this may prove to be a major difference between the UK and Netherlands in relation to sexual health promotion. Similarly increasing self-esteem and promoting future ambition may also reduce the effect of peer pressure, which may, with further research, explain some of the differences between the Netherlands and Scotland in their sexual health and teenage pregnancy statistics (see Chapter 2, Section 2.3.6 and Chapter 3, Section 3.2).

5.1.3 Do No Harm

279. Do no harm is the ethical principal that underlines the harm-minimisation approach to sexual health. The harm-minimisation approach could be defined as an approach that seeks to be non-discriminatory and accepting of the reality of teenage sexual activity. In Scotland, it does not seek to deter these activities *per se*, but rather seeks to reduce the adverse consequences of such activities. This approach is a central tenet of the Scottish executive's draft sexual health strategy, and underpins the approach of the Healthy Respect demonstration project. It is also a key basis to the SRE program SHARE which is produced by HEBS. This approach would focus on increasing contraception use and improving the accessibility and acceptability of

contraceptive services. As noted, this approach is important, especially for those who are going to be sexually active. However, as discussed in Chapter 4, the harm-minimisation approach is considered inadequate when it is the primary focus of any strategy. This is because it is a one-size-fits-all approach that does not distinguish between those who are or soon will be sexually active and those who are not going to be. This approach can leave young people feeling pressure to be sexually active. Nor does the harm-minimisation approach address the underlying reasons and non-sexual needs which often motivate sexual activity.

280. There is also concern about the lack of the evidence base for the heavy emphasis put on increasing access to sexual health clinics and linking such services to school-based SRE and improving contraception availability. Owing to unreliable statistical analysis, there is no evidence as yet as to the effectiveness of such approaches in either reducing teenage pregnancy or significantly increasing condom use. The evidence that is available from the USA confirms the findings that neither teenage pregnancy rates nor condom usage were significantly affected (see Chapter 1, Section 1.4.2). Such approaches in SRE should therefore be seriously challenged and this calls into question the likely effectiveness of this aspect of the Scottish Executive's draft sexual health strategy.

281. Physical harm-minimisation should not be the only approach to sexual health for the above reasons. The Scottish Executive's draft sexual health strategy acknowledges the broad influences on sexual behaviour and the need for preventative measures. This paper has suggested some broader preventative approaches that need to be put into SRE and social policies. As mentioned above such approaches include seeking to improve the closeness between parents and their children, increasing the connectedness of young people to school, addressing social exclusion, and seeking to help young people ask the fundamental questions about sexual relationship such as *'What is love?'* and understanding the issue of how sex can be used to fulfil non-sexual needs.

282. Another key preventative approach discussed in section 5.1.4 should be the promotion of the young person's very best interest by providing information on the benefits of delaying sexual activity. Harm-minimisation should not be utilised at the expense of incorporating other ethical principles into SRE and sexual health promotion which take, for example, a 'very best interest' approach.

283. Results from the SHARE material suggest that sex education may have reached the limits of its effectiveness in its current teacher-delivered form. It is proposed in the Scottish Executive's draft sexual health strategy that the effectiveness of SHARE, and other SRE programs, can be improved by strengthening the links between these programmes and contraceptive services. However, in light of the need for a broader preventative approach to improving sexual health and, in view of experience from the USA, SHARE should more fully incorporate a message of encouraging delay as being in the young person's best interest and provide information on the positive reasons for delaying sexual activity. Considering the fact that the Scottish Executive's draft sexual health strategy describes SHARE as an 'abstinence-plus' program, it is regrettable that it does not provide sufficient material on encouraging delay. The incorporation of such information would better reflect the collaborative goal that the draft Strategy highlights. A broad consensus between parents, teachers and professionals that sexual relationships are best delayed until the young person is older would then be recognised (see Chapter 1, Section 1.5.4). Providing such information would also ensure a more ethical approach in promoting informed choice amongst young people.

284. In summary, the harm-minimisation approach should be balanced by preventative approaches and the full outworking of other ethical principles such as full information provision and the promotion of the very best interests of the young person.

RECOMMENDATIONS

- **The Scottish Executive should give priority to preventative approaches to sexual health that include the promotion of the young person's very best interest and not just to harm-minimisation approaches that have a limited evidence-base for effectiveness. In doing so the Scottish Executive's forthcoming sexual health strategy should seek to be both ethical and preventative.**

- **In the light of Article 17 of the UN Convention on the Rights of the Child, the Scottish Executive's forthcoming sexual health strategy, in its media advocacy work, should promote positive role models in order to challenge incorrect messages such as *'everyone is having* sex' and use the media to communicate the benefits of delay and abstinence.**

- **To reduce the influence of negative peer pressure on young people, the Scottish Executive should seek practical measures to support and encourage stable family life in order to provide a greater source of self-esteem for young people.**

- **Programmes seeking to increase the connectedness of young people to school and encouraging them to have educational goals for their lives should continue to be promoted and developed as an important preventative measure by the Scottish Executive.**

- **The Scottish Executive, in collaboration with local authorities, should continue to target resources to areas of economic deprivation.**

5.1.4. Best Interest

285. The ethical principal of best interest should be promoted as the primary focus of SRE. This is in line with Article 3 of the UNCRC. It is the contention of this report that best interest should be evidence-based in providing young people with relevant information. There are questions over the competence of some young people to make informed and mature decisions about sexual relationships (see Chapter 2, Section 2.3.3 and Chapter 4, Section 4.3.1.(a)). Additionally, there are concerns over the greater risks associated with sexual activity among younger teenagers including poor contraceptive use, more sexual partners and increased regret. These all reflect the low levels of *'competence'* reported amongst many teenagers in relation to sex in the NATSAL study (see Chapter 1, Section 1.3.1). Therefore, it is suggested that the best interest approach, according to the evidence, would encourage delay in sexual activity until the young person is older and more capable of making informed decisions. Whilst wishing to avoid coercion, specific provision of information on what is in the very best interests of the young person must be the central goal of sex education programs and wider sexual health promotion. Only by doing so can fully informed choice be promoted. Encouraging abstinence and delay in the onset of sexual activity should assist young people to develop and consider the big questions of what they want from a relationship and prevent them from succumbing to peer pressure to engage in sexual activity.

286. Further to the discussion about SHARE above, it is argued that there should be more explicit encouragement of delay as this is in the best interests of the young person. SHARE should, therefore, provide information on the positive reasons for delaying sexual activity rather than just briefly focusing on developing the skills to say no to sex. Promoting best interest is not about imposing a morality, it is providing young people with the evidence-based results and all the information they need in order to make their own informed choices. The choice should remain with the young person. Currently the major initiative and programmes in Scotland (Healthy Respect and SHARE) prioritise a physical harm minimisation approach. This is also reflected in the Scottish Executive's draft sexual health strategy. However, it is important that promotion of the young person's very best interest is put forward and not just the focus on harm-minimisation. This would ensure that sex education and health promotion becomes more ethical in its information provision.

RECOMMENDATIONS

- **The Scottish Executive should determine the very 'best interest' for the young person as being the promotion of delay and abstinence until the young person is older and more able to make his or her own informed decisions.**

- **The Scottish Executive should ensure that the very best interest of the young person is promoted as the main priority of sex and relationships education and sexual health work, and that this is evidence based in its approach.**

5.1.5. Rights

287. As argued in Chapter 1 (see Section 1.5.4) the Scottish Executive's draft sexual health strategy seeks to be based on a 'rights-based' approach. It is important, however, that the forthcoming strategy incorporates all the relevant articles of the UN Convention on the Rights of the Child. In doing so the rights of the child or young person to health care services, to education and to access information through the media will remain central. However this will be balanced by the need to ensure that information is appropriate to the child's or young person's stage of cognitive development, age and maturity. The strategy should also recognise (under Article 3 of the Convention) that the very 'best interest' of the child or young person is promoted by encouraging delay and abstinence. Additionally, the implication of Article 17 of the Convention is that in its proposed media strategy the Scottish Executive should emphasise the evidence-based benefits of delay and abstinence. Perhaps most importantly in order to achieve wide public support for the forthcoming Strategy, the primary role and rights of parents in taking responsibility for their child's upbringing should be recognised and respected.

The Importance of Parents

288. The Scottish Executive's draft sexual health strategy does recognise the important role of parents in relation to SRE and argues that help should be provided to parents to enable them to fulfil this vital role (see Chapter 1, Section 1.5.4). An effort to incorporate parents back into the education of their children regarding sexual relationships is essential (see Chapter 2, Section 2.4.1 – 2.4.3.). It is clear that good parental communication, monitoring and relational closeness are all related to less sexual activity and risk behaviour in young people. It should be acknowledged that not all children experience good communication and relationships with parents and some children may not even know their parents. Nevertheless, the family remains the defining environment for most young people and parental input a key influence. There is growing evidence for the effectiveness of open and loving communication in encouraging delay and healthy behaviour in adolescents (see Chapter 2, Section 2.4.1-2.4.3.). It is essential to re-empower parents, where possible, in their role as primary educators. Arguably the involvement of parents in delivering SRE to their own child is an obligation under Articles 5, 14 and 18 of the UN Convention on the Rights of the Child.

289. Not only do parents have rights regarding, and the primary responsibility for, the education of their children, but arguably they are also best placed to judge the competence of their child to handle information on sex and relationships. It should be acknowledged that many parents do not feel equipped to deliver SRE to their child or lack the confidence to do so. Schools have traditionally taken on SRE under delegated authority from parents, a point mentioned in the Scottish Executive's draft sexual health strategy (see Chapter 1, Section 1.5.4.). However, it may be that the balance has been lost and that specific initiatives need to be taken to reintegrate parents back into SRE. Parents are most able to assess the stage of cognitive development of their individual child and therefore the appropriateness of information that should be provided. This suggests that parents should be more intricately involved in SRE relating to their own children (see Chapter 2, Sections 2.3.3 and 2.6). To do so may require more than just allowing parents the right to withdraw their child from SRE, but rather schools, education authorities and health boards proactively seeking to reintegrate parents into SRE and sexual health promotion, through the use of mechanisms such as homework assignments. To reintegrate parents they will need access to all the information necessary in order to help them understand both what their children are experiencing and what they are being taught. Not only should young people be given SRE that incorporates all the ethical principles to enable genuine informed choice, but parents should also be provided with all the information they need so that they can help their children make informed choices. This would require considerable care and work, but is necessary in order to reintegrate parents into the role of equipped educators. However, experience from the USA shows that it is not only possible to involve parents in their child's SRE programme, but also that this potentially brings significant benefits (see Chapter 3, Section 3.3.3).

290. Without parental support and cooperation, the forthcoming sexual health strategy is unlikely to have the kind of impact that is required to reverse the current high rate of teenage pregnancy and increasing rates of STIs. To gain parental approval there is an urgent need to research the wishes of parents and to reflect this in SRE and wider sexual health settings.

291. Because parents have rights with regard to their children and the way they are brought up, it is essential that schools, local education authorities and health boards are accountable to parents in their work in SRE and wider sexual health promotion. The McCabe Report highlights the need to have schools and local education authorities accountable to parents in the teaching of SRE and acknowledges the vital role of parents as educators of their children in this area from an early age. The involvement of parents is also required by Circular 2/2001 which provides statutory guidance on the conduct of SRE and is issued under the Standards in Scotland's Schools etc. Act 2000. It is vital for the integrity of these documents that their recommendations about parental involvement in SRE are fully adhered to (see Chapter 1, Section 1.5.3.). Further, it is necessary to understand what parents want with regard to SRE. There is a need for further research in order to understand the wishes of parents with regard to the content of SRE and wider sexual health education. One area of concern however is the lack of accountability of health boards to parents as recommended by the McCabe Report and as required by education authorities through Circular 2/2001. Health boards do not appear to come under this legal framework and hence are not obliged to consult parents regarding their sexual health work with young people. The legal framework outlined by the McCabe Report and Circular 2/2001 should be fully extended to health boards in their work within the school context and broader youth settings (see Chapter 1, Section 1.5.3.).

RECOMMENDATIONS

- **As a priority preventative measure, the Scottish Executive should recognise the role of parents in determining the cognitive stage of their individual child and therefore the importance of parental involvement in SRE.**
- **The Scottish Executive should encourage parental involvement and training in SRE.**
- **The Scottish Executive should initiate independent academic research in order to more fully understand what values and information parents want their children to be taught in SRE and wider sexual health education.**
- **The Scottish Executive should promote healthy and open communication between parents and children regarding sex and relationships.**
- **The Scottish Executive should review the implementation of Circular 2/2001 to ensure that local authorities and schools are fulfilling their obligation to consult with and inform parents regarding the content of SRE programmes.**
- **The legal framework provided by Circular 2/2001 should be extended to health boards in their sexual health work with schools and general youth settings.**

5.2. Conclusion

292. This report concludes that a range of ethical principles should be fully applied to SRE and sexual health education in Scotland. These ethical principles are the provision of all the necessary information, freedom of choice, doing no harm and the promotion of very best interest. In the application of these ethical principles it is important to have due regard to the age and stage of cognitive development of the person concerned. The ethical principles must be accompanied by an emphasis upon respecting the full range of rights contained in the UN Convention on the Rights of the Child, including giving recognition to the rights of parents to play a primary role in their child's SRE. The legislative and policy mechanism are already in place in Scotland. These mechanisms represent the best possible consensus approach and it is important that the Scottish Executive ensures their implementation. The experience of the Netherlands, the USA and Uganda show that family bonds, abstinence-based SRE programmes and the encouragement of being faithful to one partner can improve sexual health and reduce unwanted teenage pregnancy. The Scottish Executive should prioritise these factors in finalising its forthcoming sexual health strategy.

Appendix 1

Summary of Recommendations

Ethics

- **The incorporation of all the ethical principles outlined in Chapter 4 into SRE should be encouraged by the Scottish Executive as of first priority in order to promote responsible behaviour based on sound principles and fully informed choice amongst young people.**

- **The Scottish Executive should take into account the ability of individual young people to make competent decisions about sexual relationships at different ages and stages of cognitive development.**

Information Provision

- **In the provision of biological information, the Scottish Executive should ensure that information is given on the scientific effectiveness of condoms in preventing STIs, in addition to user-failure rates, to ensure that informed choice is promoted. Particular reference should be made to HPV and the fact that condoms offer very little protection against this particular STI.**

- **Sex and relationships education should seek to help young people consider what sex is within the context of love and relationships as required by the Scottish Executive Education Department Circular 2/2001.**

- **The Scottish Executive's forthcoming sexual health strategy should ensure that young people are aware that sex is often used to fulfil non-sexual needs and that alternatives exist which may address these needs.**

- **The Scottish Executive should ensure that schools provide information concerning sexual relationships that is understandable to the young person and appropriate to their age and stage of cognitive development.**

Harm-minimisation and preventative approaches

- **The Scottish Executive should give priority to preventative approaches to sexual health that include the promotion of the young person's very best interest and not just to harm-minimisation approaches that have a limited evidence-base for effectiveness. In doing so the Scottish Executive's forthcoming sexual health strategy should seek to be both ethical and preventative.**

- **In the light of Article 17 of the UN Convention on the Rights of the Child, the Scottish Executive's forthcoming sexual health strategy, in its media advocacy work, should promote positive role models in order to challenge incorrect messages such as *'everyone is having* sex' and use the media to communicate the benefits of delay and abstinence.**

- **To reduce the influence of negative peer pressure on young people, the Scottish Executive should seek practical measures to support and encourage stable family life in order to provide a greater source of self-esteem for young people.**

- **Programmes seeking to increase the connectedness of young people to school and encouraging them to have educational goals for their lives should continue to be promoted and developed as an important preventative measure by the Scottish Executive.**

- **The Scottish Executive, in collaboration with local authorities, should continue to target resources to areas of economic deprivation.**

Best Interest

- **The Scottish Executive should determine the very 'best interest' for the young person as being the promotion of delay and abstinence until the young person is older and more able to make his or her own informed decisions.**

- **The Scottish Executive should ensure that the very best interest of the young person is promoted as the main priority of sex and relationships education and sexual health work, and that this is evidence based in its approach.**

Parents

- **As a priority preventative measure, the Scottish Executive should recognise the role of parents in determining the cognitive stage of their individual child and therefore the importance of parental involvement in SRE.**
- **The Scottish Executive should encourage parental involvement and training in SRE.**
- **The Scottish Executive should initiate independent academic research in order to more fully understand what values and information parents want their children to be taught in SRE and wider sexual health education.**
- **The Scottish Executive should promote healthy and open communication between parents and children regarding sex and relationships.**
- **The Scottish Executive should review the implementation of Circular 2/2001 to ensure that local authorities and schools are fulfilling their obligation to consult with and inform parents regarding the content of SRE programmes.**
- **The legal framework provided by Circular 2/2001 should be extended to health boards in their sexual health work with schools and general youth settings.**

Appendix 2

Articles from the UN Convention on the Rights of the Child Of Relevance to Sex and relationships education

Article 3: *'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration.'*

Article 5: *State Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of rights recognized in the present Convention.'*

Article 6: *'2. State Parties shall ensure to the maximum extent possible the survival and development of the child.'*

Article 12: *'1. State Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.'*

Article 13: *'1. The child shall have the right to freedom of expression; this right shall include freedom to seek receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.'*

Article 14: *'1. State Parties shall respect the right of the child to freedom of thought, conscience and religion.'*

Article 17: *'State Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health. To this end, State Parties shall:*

Encourage the mass media to disseminate information and material of social and cultural benefit to the child and in accordance with the spirit of Article 29'.

Articles 18: 1. *State Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.*

Article 29: *'1. State Parties agree that the education of the child shall be directed to:*
The development of the child's personality, talents and mental and physical abilities to their fullest potential;

The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;
The development of respect for the child's parents, his or her own cultural identity, language and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own;
The preparation of the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin;'

Article 34: *'State Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, State Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:*
The inducement or coercion of a child to engage in any unlawful sexual activity;'

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