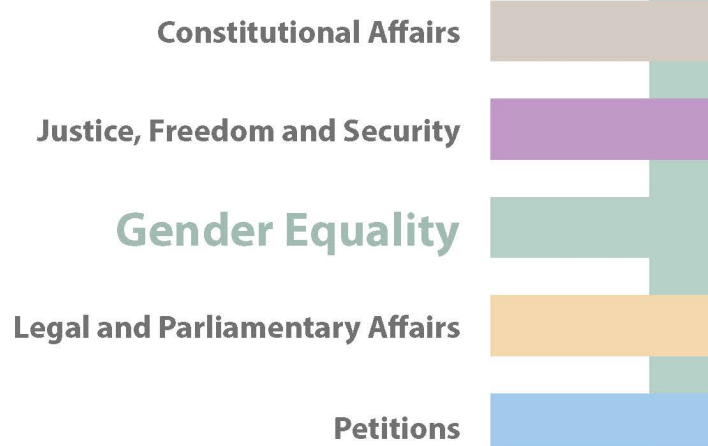


DIRECTORATE-GENERAL FOR INTERNAL POLICIES

**POLICY DEPARTMENT** **C**  
CITIZENS' RIGHTS AND CONSTITUTIONAL AFFAIRS



# Sexual and reproductive health and rights

STUDY FOR THE FEMM COMMITTEE





**DIRECTORATE GENERAL FOR INTERNAL POLICIES**  
**POLICY DEPARTMENT C: CITIZENS' RIGHTS AND**  
**CONSTITUTIONAL AFFAIRS**

**WOMEN'S RIGHTS & GENDER EQUALITY**

# **Sexual and reproductive health and rights**

## **STUDY**

### **Abstract**

Upon request by the FEMM Committee this study updates knowledge on the provision of sexual education and reproductive rights in the European Union. It involved a review of recent research and data on sexual and reproductive health, and case studies in Denmark, Spain and the United Kingdom. Good quality sexual and relationship education (SRE) reduces risk of sexually transmitted infection, unplanned pregnancy and sexual exploitation amongst young people. However, the implementation of sex and relationship education is inconsistent across Member States.

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## LIST OF ABBREVIATIONS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>APF</b>	Portuguese Family Planning Association
<b>APFM</b>	Spanish Federation of Family Planning
<b>BFPA</b>	The Bulgarian Family Planning and Sexual Health Association
<b>BMG</b>	German Federal Ministry for Health
<b>BZgA</b>	The Federal Centre for Health Education, Germany
<b>CCAA</b>	Autonomous Community
<b>CEDAW</b>	The Convention on the Elimination of all Forms of Discrimination Against Women
<b>CFPA</b>	Cyprus Family Planning Association
<b>CoE</b>	Council of Europe
<b>CRC</b>	Convention on the Rights of the Child
<b>DfE</b>	Department for Education
<b>EC</b>	European Commission
<b>ECDC</b>	European Centre for Prevention and Disease control
<b>EEA</b>	The European Economic Area
<b>EP</b>	European Parliament
<b>EU</b>	European Union
<b>FEMM</b>	EP's Women's Rights and Gender Equality
<b>FPA</b>	Family Planning Association
<b>FRA</b>	European Union Agency for Fundamental Rights
<b>FPSHA</b>	Lithuanian Family Planning Association
<b>GROZD</b>	Croatian association Parents' Voice For Children

<b>HVI</b>	Human immunodeficiency virus
<b>ICESR</b>	International Covenant on Economic, Social and Cultural Rights
<b>ICPD</b>	International Conference on Population and Development
<b>IFPA</b>	Irish Family Planning Association
<b>INE</b>	Spanish National Institute of Statistics
<b>IPPF</b>	International Planned Parenthood Association
<b>LAPFSH</b>	Latvian Association for Family Planning & Sexual Health
<b>LGE</b>	General Law of Education
<b>LGTBI</b>	Lesbian, Gay, Bisexual, Transgender and/or intersex
<b>LGV</b>	<i>Lymphogranuloma venereum</i> disease
<b>LOCE</b>	Ley Orgánica Constitucional de Enseñanza
<b>LOE</b>	Ley Orgánica de Educacion
<b>LOECE</b>	Ley Orgánica por la que se regula el Estatuto de Centros Escolares
<b>LOGSE</b>	Ley Orgánica General del Sistema Educativo
<b>LOMCE</b>	Ley Orgánica para la Mejora de la Calidad Educativa
<b>MSSSI</b>	Spanish Ministry of Health, Social Services and Equality.
<b>NGO</b>	A non-governmental Organization
<b>Ofsted</b>	Office for Standards in Education, Children's Services and Skills.
<b>ONS</b>	Office for National Statistics
<b>PP</b>	Spanish Popular Party
<b>PSHE</b>	Personal, social, health and economic education
<b>PSOE</b>	Spanish Socialist Workers' Party
<b>RFSU</b>	The Swedish Association for Sexuality Education
<b>RSE</b>	Relationships and Sexuality Education



<b>SAFE</b>	Sexual Awareness for Everyone
<b>SFHÄndG</b>	Schwangeren- und Familienhilfeänderungsgesetz, Germany
<b>SRH</b>	Sexual and reproductive health
<b>STI</b>	Sexually transmitted infections
<b>STIR</b>	Safeguarding Teenage Intimate Relationships
<b>UCD</b>	Union of the Democratic Centre, Spain
<b>UK</b>	The United Kingdom
<b>UN</b>	United Nations
<b>UNAIDS</b>	United Nations Programme on HIV/AIDS
<b>UNESCO</b>	The United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	The United Nations Population Fund
<b>WHO</b>	World Health Organisation

## **LIST OF FIGURES**

**FIGURE 1:**

The new WHO European Action Plan for SRH and Rights 2017-2021

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## EXECUTIVE SUMMARY

### Aims and methods

This study was commissioned by the Women's Rights and Gender Equality Committee (FEMM) of the European Parliament to explore and update knowledge on the provision of sexual education and reproductive rights in the European Union. It involved a review of recent research and data on sexual and reproductive health, and case studies in Denmark, Spain and the United Kingdom.

### Key findings

Robust research demonstrates that sexual education programmes do not result in earlier sexual behaviour and indeed, reduce risky sexual behaviours amongst young people. Further, research also finds that a rights-based comprehensive sexual and relationship education protects children and young people against the risk of abuse, sexual exploitation and domestic violence (Kohler et al, 2008, CoE, 2011). Further, existing research (e.g. Barter and Stanley, 2009; Schütt et al, 2008) finds that young women, aged under 25, including girls who are still at school, are particularly at risk of violence from their 'partners/boyfriends' and that up to 1 in 4 boys / young men hold negative views of women and girls. Our case studies support the view that a holistic, rights-based sexual and relationship education which emphasises consent, well being, avoiding risk and respect is an effective approach for reducing these negative phenomena.

There is a strong international consensus that sex and relationship education (SRE) is most effective when delivered in a positive human rights framework, rather than a reductive biomedical disease prevention approach.

There are continued concerns about levels of sexually transmitted infection, violence and abuse in intimate relationships, particularly amongst young people. Good quality SRE is linked to reductions in rates of sexually transmitted infection, unplanned pregnancy, and levels of risk of sexual exploitation among young people. It is also widely felt necessary to reduce the risk of violence and abuse in intimate relationships.

The provision of good quality sex and relationship education, advice and support is strongly supported in various conventions to which the EU and Member States are signatories, notably the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW, 1979) and the Convention on the Rights of the Child (1989).

At the time of writing, sexual and health education provisions in some form are mandatory at a national level in 20 out of the 28 countries of the EU. However, it is notable that in some countries (i.e. Spain, Croatia, and Poland) SRE policy has shifted towards a more socially conservative approach in the last few years. In practice, despite the mandatory or statutory footing of SRE in many Member States, its implementation is inconsistent between and within countries in terms of quality and quantity.

All three case study countries have a long tradition of providing some form of sexual education to young people. However, each of these countries has also seen recent increase in resistance to SRE being provided. There are growing concerns around young people's sexual health and emotional wellbeing in all case study countries, including, for example, increasing rates of sexually transmitted infections in Denmark and the UK, and concerns about young people's experiences of abuse in intimate relationships in Denmark, Spain, and the UK.

Particular concerns were expressed about the lack of sex and relationship education that is specific to the experiences of lesbian, gay, bisexual, transgender and intersex (LGBTI) people. As well as ignoring the needs and issues of LGBTI people, this has led to a worrying lack of knowledge about how HIV is transmitted amongst young men, for example.

Concerns were expressed in all case study countries about young people's exposure to misleading information about sexual practice through online pornography and the risk of sexual exploitation through online and social media platforms.

Even where it is mandatory to provide SRE in schools in some form, such as Denmark and the UK, there remain significant means by which schools and parents may avoid doing so. In Spain there is no mandatory provision of SRE in schools although local authorities may provide funding to schools for this purpose. This situation leads to inconsistency in quality and quantity of SRE provision in schools.

## **Recommendations**

Recommendations to the European Parliament and European Commission follow from this study. These are:

- To strongly advise Member States to be consistent in their implementation of SRE, including issuing recommendations about the minimum amount of time pupils spend on it.
- To monitor the implementation of SRE policies.
- To invest in research and monitoring of students' knowledge on SRE subjects.
- To invest in research to construct a compelling evidence base demonstrating what young people want from SRE.
- To invest and support NGOs to research and refresh SRE teaching materials, including making such materials available online.

## **1. INTRODUCTION**

### **1.1. Aims of the study**

This study was commissioned by the Women's Rights and Gender Equality Committee (FEMM) of the European Parliament to explore and update knowledge on the provision of sexual education and reproductive rights in the European Union. The focus is particularly on the provision of sexual and relationship education (SRE) and how this impacts on reproductive health and well-being.

### **1.2. Methodology**

A literature review of recent research, policy and legislation at the EU level and in various member states was undertaken. From this, a summary of important characteristics of the provision of SRE and other issues was developed. In order to explore the implications of these characteristics, case studies of three different member states were carried out, for Denmark, the United Kingdom and Spain. This involved further literature reviews and interviews with key actors. Several types of respondents were chosen to create the sample for the study. All respondents were selected because they either have direct experience of delivering sexual education or sexual health services or because they have been involved directly in organising policy relating to the subject. Thus, the following respondent groups were included:

#### **Denmark:**

- Staff from the leading national provider of Sex and Relationship Education
- Representatives from the Ministry of Education

#### **UK:**

- Staff from the leading providers of Sex and Relationship Education
- Representatives from the government department that was at the time responsible for a review of policy on the subject

#### **Spain:**

- Staff from the leading national provider of Sex and Relationship Education
- Individual teachers

It should be noted that a number of other respondent groups were invited to take part in the study but for various reasons were not or did not participate.

## 2. LITERATURE REVIEW

### KEY FINDINGS

- There is a strong international consensus that sex and relationship education (SRE) is most effective when delivered in a positive human rights framework, rather than a reductive bio-medical disease prevention approach.
- Good quality SRE is linked to reductions in rates of sexually transmitted infection and unplanned pregnancy.
- Good quality SRE is linked to reductions in levels of risk of sexual exploitation among young people.
- Good quality SRE is linked to reductions in rates of violence and abuse in intimate relationships.
- Good quality SRE and reproductive health protection is encouraged in various international agreements and conventions to which the EU and Member States are signatory.

### 2.1. Background

The World Health Organisation (WHO) defines sex and relationship education as, 'learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. [...] It gradually equips and empowers children and young people with information, skills and positive values to understand and enjoy their sexuality, have safe and fulfilling relationships and take responsibility for their own and other people's sexual health and well-being' (IPPF, 2015)

According to Sexual Awareness for Everyone (SAFE), there are many different terms used to discuss the process of educating and informing people, and particularly young people, about sexual behaviour, relationships and sexual health. For the purposes of this report, the term sex and relationship education (SRE) will be used throughout. There is a diversity of approaches to providing SRE between countries. An important distinction is between education that focuses on biological and sexual health issues, and education that positions SRE in the context of broader health and social education.

The last two decades have seen an increase in calls for sexual and reproductive health to be viewed within a positive rights framework, which supports responsible practices of sexual behaviour and sexuality, as well as reproductive health, citizenship and responsibility. This approach is encouraged by the WHO, which advocates for sexuality education and reproductive health to be framed within a human rights context: 'Good quality sexuality education is grounded in internationally accepted human rights, in particular the right to access appropriate health-related information' (WHO, 2013).

### 2.2. Evidence on the impact of SRE

Effective SRE seeks to address the cognitive, emotional and psycho-social aspects of everyday life (Suciu *et al.*, 2015), delivering information needed by young people to develop

their relationships, stay healthy and address the social and psychological aspects of their sexuality. However, there are examples where government-mandated SRE provision is limited to the biological aspects of sex, pregnancy and disease prevention. These are elucidated in subsequent sections of this report.

The impact of SRE on the health and well-being of young people can be considerable, including improved uptake of contraception and therefore a reduction in pregnancies in under 18 year olds, reductions in abortions, fewer sexually transmitted infections including HIV infections, and a reduction in sexual abuse and homophobia (e.g. Suciú *et al.*, 2015; WHO, 2015; Wellings *et al.*, 2016). SRE gives young people accurate information about issues such as sexual abuse, gender-based violence and harmful practices like female genital mutilation, and explores positive values and attitudes such as self-esteem, respect for human rights and gender equality. It can also empower young people to develop skills such as critical thinking, communication and negotiation (e.g. WHO, 2015; Ofsted, 2013; PHSE Association, Sex Education Forum UK, 2014).

Evidence from academic research and an evaluation from policy programmes (UN, 1997) show how young people who have received comprehensive sexual education are less likely to experience negative sexual health outcomes such as STI, see rates of pregnancy declined and being more successful in the use of contraception and condoms (e.g. Kirby 2006, 2007; UN, 1997). Moreover, robust research demonstrates that sexual education programmes do not result in earlier sexual behaviour and indeed, reduce risky sexual behaviours amongst young people. In their epidemiological study comparing young people aged 15-19 in the USA, Kohler and colleagues found that 'Teaching about contraception was not associated with increased risk of adolescent sexual activity or STD'. Furthermore, 'Adolescents who received comprehensive sex education had a lower risk of pregnancy than adolescents who received abstinence-only or no sex education'. (Kohler *et al.*, 2008)

Importantly, comprehensive SRE can provide a framework that equips children and young people to recognise sexual exploitation and abuse or violence when they occur, to protect themselves as far as possible and to identify and access available sources of support (Brook, Sex Education Forum; PSHE Association 2014). Research finds that between 20 and 27% of all women in the European region have experienced physical violence at least once during their adult lives and more than one-tenth have suffered sexual violence involving the use of force (Suciú *et al.*, 2015; WHO, 2013). Sexual vulnerability is also linked to other forms of risk and vulnerability, such as racism and homophobia, and drug and alcohol use, and to gender inequality and violence in the household, and this should be recognised in SRE delivery (CoE, 2011). Conversely, failure to inform children and young people about boundaries, consent and indicators of dangers of sexual exploitation and abuse may create and sustain vulnerability to sexual coercion, abuse and exploitation (*ibid.*, 2011).

In 2009 UNESCO argued that sexuality education has a number of mutually reinforcing objectives. These include:

- Increasing knowledge and understanding.
- Exploring and clarifying feelings, values and attitudes.
- Developing and reinforcing skills and communication.
- Promoting and sustaining risk-reducing behaviour.

There is consistent evidence of the need to address sexual health and sexual behaviours in terms of sexually transmitted infection (STI) rates. Rates of various STIs have been increasing, particularly among young people. In 2013, 384,555 cases of chlamydia trachomatis infection were reported in 26 EU/EEA Member States (an overall rate of 182 notifications per 100,000 population) (ECDC, 2013). Two-thirds (67%) of all chlamydia trachomatis infections were reported in young people between 15 and 24 years of age, with

the highest rates reported among women aged 20 to 24 years. The overall rate of reported chlamydia increased by 68% between 2004 and 2013, although this is likely to be due in part to increases in detection. Since 2008, the rate of gonorrhoea cases per 100,000 population has increased by 79%, with young adults contributing 39% of cases. Since 2010, the overall syphilis infection rate has been increasing, particularly among men. The majority of syphilis cases were reported in people older than 25 years. Compared with 2012, the number of reported cases of *lymphogranuloma venereum* (LGV) increased by 22%. According to Eurostat (2009), in 2006, nearly 30% of new HIV cases were diagnosed among young people aged between 15 and 29, almost two thirds of which (60%) concerned those aged between 25 and 29 years. Furthermore, there are significant increases in the proportion of new HIV diagnoses in men who have sex with men across Europe (ECDPC, 2015).

There is a strong international consensus that a positive health approach which aims to reduce risk rather than advocating abstinence is the most effective way of protecting young people and safeguarding their well-being. This consensus is reviewed below.

### **2.3. International conventions and agreements connected with SRE**

Inter-governmental agreements mandate that SRE incorporates certain core criteria, including a commitment to embedding gender equality in SRE programmes.

The landmark 1994 International Conference on Population and Development (ICPD) Programme of Action endorsed an ambitious population and development strategy. Its focus on promoting human rights, advancing gender equality and improving sexual and reproductive health as cornerstones of the population and development agenda led to a paradigm shift in which universal access to sexual and reproductive health (SRH) and the promotion and protection of reproductive rights became seen as paramount. It explicitly calls on governments to provide education on sexuality.

The UN's 2015-30 Sustainable Development Goals (2016) built on the Millennium Development Goals' pledge to reduce maternal mortality rates with a more comprehensive commitment to 'ensure universal access to sexual and reproductive health care services, including for family planning, information and education and the integration of reproductive health into national strategies and programmes by 2030' (Goal 3:7) and to 'ensure universal access to SRH and reproductive rights' (Goal 5:6). Goal 5:2 also calls for the elimination of 'all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.'

The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), is an international human rights convention for the advancement of women and gender equality. The Convention, described as the bill of rights for women, was drafted by the UN Commission on the Status of Women and was formally adopted in 1979. Several Articles to the Convention address the need for SRE. Article 12 obligates the States to take all appropriate measures to eliminate discrimination against women in health care so that, in order to ensure equality between women and men, access to healthcare services are equal. This includes healthcare relating to family planning services, pregnancy, confinement and the post-partum period. In addition, the Article 12 underlines women's right to freely determine the timing and the number of children - regardless of their marital status (UN Committee on the Elimination of Discrimination Against Women, 1999).

Article 24:2.f of the Convention on the Rights of the Child (CRC) calls for States Parties to 'develop preventive health care, guidance for parents and family planning education and services.' In the case of the UK for example, it has strengthened this call by pushing for the UK to 'Ensure that meaningful sexual and reproductive health education is part of the



mandatory school curriculum for all schools. [...] Such education should provide age-appropriate information on: confidential sexual and reproductive health-care services; contraceptives; the prevention of sexual abuse or exploitation, including sexual bullying; the support available in cases of such abuse and exploitation; and sexuality, including that of lesbian, gay, bisexual, transgender and intersex children' (CRC, 2016).

International agreements set out global standards for the protection from and prosecution of sexual violence, including through education. The CRC calls on states parties to, 'take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse', (article 19:1, emphasis added). CEDAW's General Recommendation No. 19 on Violence Against Women recommends that education and public information programmes should be introduced to overcome attitudes, customs and practices that perpetuate violence against women and the kinds of violence that result. It calls on States Parties to report on measures taken to protect women from sexual exploitation, and ensure that measures are taken to prevent coercion in regard to fertility and reproduction (CEDAW, 1992).

## 2.4. EU-level policy and legal framework

There have been efforts to develop regional standards with regard to SRE at the EU level.

The Council of Europe (CoE) Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) entered into force in 2014, and makes more explicit reference to SRE. As a regional instrument, the Convention complements and expands the standards set by other regional human rights organisations, reinforcing action to prevent and combat violence against women and domestic violence. Article 14 in particular recognises the role of education and educational centres in promoting gender equality, mutual respect in interpersonal relationships and non-violence as early as possible: 'Parties shall take, where appropriate, the necessary steps to include teaching material on issues such as equality between women and men, non-stereotyped gender roles, mutual respect, non-violent conflict resolution in interpersonal relationships, gender-based violence against women and the right to personal integrity, adapted to the evolving capacity of learners, in formal curricula and at all levels of education.'

In September 2015, the European Parliament adopted a resolution on empowering girls through education in the EU. The resolution, which is non-legislative and therefore only contains recommendations to Member States, calls on EU Member States to 'improve measures to apply gender equality at all levels of the education system', and particularly emphasises the need to introduce comprehensive SRE in schools in order to achieve this. It calls for girls and boys to be educated about relationships based on consent and respect, and notes the impact of comprehensive SRE on empowering young people to have awareness and control over their own bodies. In its address to the European Commission, the report calls for the Commission 'to support the inclusion of objective information on LGBTI issues in school curricula' and 'urges the Commission to facilitate peer learning amongst Member States in tackling homophobic and transphobic bullying and harassment' (European Parliament, 2015).

In 2012, the World Health Organisation Regional Committee for Europe (WHO/Europe, 2013) introduced 'Health 2020: a European Policy Framework for Health and Well-being'. This is a value and evidence-based health policy framework for the European Region. Health 2020 endeavours to improve health and reduce health inequalities, through improved leadership and governance. Health 2020 clearly ties SRE to improved health outcomes. It states: 'Access to sexuality education, family planning services and safe abortion reduces the number of unintended pregnancies and mortality and morbidity from abortion without influencing the fertility rate.' Figure one below shows the Action Plan goals and objectives:

**Figure 1: The new WHO European Action Plan for SRH and Rights 2017-2021**

<b>Goal A: Promote sexual health and well-being and sexual rights</b>	<b>Goal B: Promote reproductive health and well-being and reproductive rights</b>	<b>Goal C: Strive for universal access to sexual and reproductive health and rights and reduce inequities</b>
<p><b>Objective 1:</b> Address violations of human rights related to sexuality.</p> <p><b>Objective 2:</b> Promote people's ability to engage in safe and satisfying sexual relationships.</p> <p><b>Objective 3:</b> Attend to people's needs or concerns in relation to sexuality.</p>	<p><b>Objective 1:</b> Foster the exercise of reproductive rights.</p> <p><b>Objective 2:</b> Reduce unmet need for contraception.</p> <p><b>Objective 3:</b> Reduce avoidable maternal mortality and morbidity including that due to unsafe abortions.</p> <p><b>Objective 4:</b> Reduce avoidable perinatal mortality and morbidity.</p> <p><b>Objective 5:</b> Promote prevention and provide diagnosis and treatment for infertility.</p>	<p><b>Objective 1:</b> Establish and review sexuality education programmes.</p> <p><b>Objective 2:</b> Expand scope and reach of adolescent sexual and reproductive health services.</p> <p><b>Objective 3:</b> Establish and strengthen access to sexual and reproductive health services for populations with special needs.</p> <p><b>Objective 4:</b> Integrate sexual and reproductive health into national strategies and programmes.</p> <p><b>Objective 5:</b> Develop whole-of-government and whole-of-society approaches for effective and equitable implementation of programmes.</p>

Health 2020 also highlights the impact of gender norms and roles in shaping the way adolescents view sexuality, and attitudes to risk-taking and accessing services (WHO, 2013). For example, girls and boys are exposed to different types of risks and constraints that affect their vulnerability 'to health risks and conditions such as depressive disorders, accidents, substance abuse, eating disorders, sexually transmitted infections, violence and self-inflicted injuries, including suicide (ibid, 2013). The document serves an important, albeit advisory, function in contributing to expert policy guidance and consensus around the importance of sexuality education for improving both health and psycho-social well-being.

Further, at its 2013 and 2014 sessions, WHO Europe initiated the development of a European Women's Health Strategy and a new European Action Plan for Sexual and Reproductive Health and Rights 2017-2021, to reflect the objectives of Health 2020. In 2016, WHO presented the Plan 'Towards achieving the 2030 Agenda for Sustainable Development in Europe- no one behind' which was adopted by the 66th session of the WHO Regional Committee for Europe in September 2016. Hungary, Poland and Turkey disassociated themselves from the Action plan. The Action Plan has three closely interlinked goals: 'Enable all people to make informed decisions about their sexual and reproductive health and ensure that their human rights are respected, protected and fulfilled', 'Ensure that all people can enjoy the highest attainable standard of sexual and reproductive health and well-being' and

'Guarantee universal access to sexual and reproductive health and eliminate inequities' (WHO, 2016).

The EU has no mandate over the national curriculums set by schools in Member States, including whether and how it provides SRE. However, bodies such as the European Parliament and the European Commission (EC) have sought to influence the provision of SRE, including in relation to the prevention of STIs and domestic abuse. For example, the EC funds alongside the IPPF European Network and the WHO Regional Office for Europe the 'The SAFE project', a European partnership to promote the sexual reproductive health and rights of young people.

In order to fulfil the health goals for the 2020 strategy, the EU has instituted the Third Health Programme 2014-2020. This programme aims to 'Promote health, prevent diseases, and foster supportive environments for healthy lifestyles' in Member States. However, the EU does not address specifically any issue regarding SRE in schools in their education goals of the 2020 strategy.

Both the EC and the EP regularly commission research and reports about SRE such as Policies for Sexuality Education in the European Union (2013) with the aim of educating and informing policy makers to pursue good practice.

The various global accords signify an evolution towards global institutions' commitment to SRE as a fundamental human right. However, despite this, the implementation of SRE in each Member State is inconsistent and has been met with a variety of challenges. These challenges are explored in greater depth in the following report.

## **2.5. Best practice in SRE provision**

In its 2015 report, 'Comprehensive Sexuality Education: A Global Review', the United Nations Educational, Scientific and Cultural Organization (UNESCO) sets out core elements of SRE as being grounded in human rights and reflecting a broad concept of sexuality as a natural part of human development (UNESCO, 2015).

Effective SRE can be delivered using various methodologies and should be adapted to ensure cultural relevance in accordance with national laws and policies. Nevertheless, core criteria of a rights-based approach to SRE curricula include addressing sexual and gender-based violence and promoting gender equality; meeting the needs and protecting the rights of all young people, including those living with HIV; increasing understanding of one's body and entitlements to rights (including the right to give or withhold consent); improving self-esteem; and acquiring skills (CoE, 2015). Furthermore, SRE is best delivered by trained and trusted professionals. Teachers are considered to be best placed to provide SRE, although health professionals and trained and supervised peer educators can support the process (UNESCO, 2007).

Scaling up SRE by engaging parents and communities in its implementation is found to be essential for bolstering support for the subject among the school community, enhancing overall understanding of the issues facing young people and securing a mature and open dialogue about SRE within the general public (UNESCO, 2015, Lewis and Knijn, 2001).

### 3. SUMMARY OF SRE PROVISION AND OTHER INDICATORS IN 28 EU COUNTRIES

#### KEY FINDINGS

- Sexual and health education provision in some form is mandatory at a national level in 20 out of the 28 countries of the EU.
- There is wide variety in terms of the length of time over which SRE has been provided across countries.
- In some countries (notably Croatia, Latvia, Poland and Spain), SRE policy has shifted toward more socially conservative approaches in the last few years.
- Family Planning Associations are widely present across countries.
- Birth rates to mothers aged between 15 and 19 years range from 1.1 and 35.5 per 1000.
- The minimum age for marriage without parental consent is 18 years in every country except Malta and Slovakia, where the minimum age is 16 years

#### 3.1. Introduction

A compendium of key features of sex and relationship education and other reproductive health indicators has been assembled (see Table 1, Annex) including:

- **Existence of national legislation making SRE mandatory in schools:** establishing which countries have or have not made SRE programmes in schools mandatory.
- **Date and name of the relevant legislation or programme:** details of laws or legislative programme relevant to SRE
- **Main providers of SRE in that country:** identify bodies and organisations running SRE programmes.
- **Usual Approach to SRE:** a short description of the teaching, philosophical or theoretical approach that SRE programmes are based on.
- **LGBTI issues addressed in the SRE national curriculum:** an assessment of whether or not SRE programmes directly address the needs of or explains issues connected to being lesbian, gay, bisexual, transgender or intersex.
- **Gender based violence addressed in SRE:** an assessment of whether or not SRE programmes directly address issues connected with risks of gender based violence. These may include respect and boundaries within relationships, sexual consent, respecting one's body, exploring negative gender stereotypes
- **Live birth rate amongst under 19 year olds:** this is a measure of young age births, an indicator linked to higher rates of maternal and infant morbidity, poverty and poor health outcomes
- **Marriageable with parental consent:** a measure that indicates social norms and expectations around family forming and reproduction
- **Marriageable age without parental consent:** a measure that indicates social norms and expectations around family forming and reproduction
- **Same-sex marriage:** a measure of social acceptance of same sex relationships.

### 3.2. Summary of data

Some form of sexual and health education provision is mandatory at a national level in 20 out of the 28 countries of the EU. Eight countries (Bulgaria, Croatia, Hungary, Italy, Lithuania, Romania, Slovakia and Spain) do not stipulate that SRE is mandatory in schools.

Some countries, such as Denmark and Austria, have been implementing consistent SRE programmes since the 1970's. In others, SRE policy has been implemented only relatively recently. In the Netherlands, for example, where SRE programmes have been widely and successfully implemented for several years, SRE provision was not mandatory until 2012. Eastern European countries tend to have begun implementing SRE as communist governments began to fall.

It is notable that in some countries, SRE policy has shifted toward more socially conservative approaches in the last few years. For example, in 2011, Spain revoked its socially progressive approach towards SRE (as enacted in 2005 education legislation), leaving SRE firmly at the discretion of individual schools. In Croatia, while there was an attempt to introduce comprehensive SRE in 2013, the Catholic church and socially conservative media were largely responsible for blocking this attempt.

Some countries have kept SRE mandatory but have not supported its implementation in practice. In Poland, SRE programmes are *de jure* mandatory but, again largely due to political pressure imposed by the Catholic church and socially conservative media, parents are able to withdraw children at any point, rendering SRE *de facto* non-mandatory. A similar situation exists in the UK, where a political commitment to low levels of state intervention within what is perceived as the sphere of private life means that parents are able to withdraw their children from any component of SRE except for those covered in the science curriculum.

In 2015, Latvia amended a law from 2007 to introduce the provision of 'morality education' as a counterpoint to SRE. This placed limited emphasis on LGBTI rights and issues.

Some countries have recently made steps to restrict access to abortions. These countries also have relatively restrictive provisions for SRE. For example, in Spain (2015), after the failure of the abortion ban law in 2012, the Government restricted abortion for under those aged less than 17 years without parental consent. In 2013 Lithuania initiated legal steps towards banning abortion, a process which it is still under debate. Similarly, in Poland, where abortion is already illegal except in cases of rape, maternal morbidity or foetal abnormality, legal steps to total ban abortion were initiated in 2015. However, this was finally rejected in October 2016.

In 2013 Ireland legislated to allow abortions to be performed in certain limited cases. Thus, currently, Malta the only country in EU-28 where abortion is illegal in all circumstances.

Family Planning Associations under the IPPF umbrella are widely present in every country. In some countries, such as Denmark and Austria, they work directly with policy makers and schools to develop and implement SRE. Other Family Planning Associations such as those in Italy and Spain do not have systematic governmental support. However, they work jointly with schools to deliver SRE using WHO and EU standards and guidance.

Schools have a large impact on the way SRE is implemented. In many countries, including Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Greece, Hungary, Ireland, Italy, Spain, Lithuania, Portugal, Slovenia, Spain and the UK, schools can decide the approach, length and scope of SRE programmes.

Administrative decentralization is an important factor that impacts on SRE. For example, in Belgium and Germany, local bodies have autonomy to decide the SRE curriculum.

Of the 20 Member States with mandatory SRE in schools only 12 appear to address LGBTI issues in their curriculum. Moreover, 14 out of 20 Member States cover issues connected with gender-based violence in their national curriculum. However, it should be noted that even if these issues are not covered specifically by the curriculum, schools might provide some coverage through other mechanisms.

In 2016, figures on 'Live birth women aged Under 18 and Under 20' indicate that 15 countries out of 28 countries have birth rates below 5 per 1000 amongst women aged 15 to 19 years. These countries are Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Slovenia, Spain and Sweden. Denmark, the Netherlands and Finland have the lowest birth rates among this age group. 9 countries (Cyprus, Czech, Estonia, Latvia, Lithuania, Malta, Poland, Portugal and the UK) have birth rates between 5 and 10 per 1000 among this age group. The highest birth rates per 1000 women aged 15 to 19 years are found in Bulgaria (35.5), Romania (29.2), Slovakia (15.9) and Hungary (15.4) (ONS, 2016).

A high adolescent birth rate is seen as negative indicator as there are profound implications for the health and well being of both mother and child. In the UK for example, at least 40% of mothers under age 17 leave school with no qualifications, and both young mothers and their children have poorer health outcomes and an increased chance of living in poverty in their lifetime (Arie, 2014).

The minimum age of marriage without parental consent is 18 years in every country except Malta and Slovakia, where the minimum age for marriage without parental consent is 16 years for both men and women. There is no clear relationship between legal age for marriage and other variables within this data including country characteristics.

Amongst the 28 Member States, 11 countries have legalised same-sex marriage. These are Belgium, France, Finland, Denmark, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom. 9 Member States including Austria, Croatia, Czech, Estonia, Germany, Hungary, Italy, Malta and Slovenia have some sort of partnerships provision. Another 8 Member States do not recognise same-sex marriage at any level: Bulgaria, Cyprus, Greece, Latvia, Lithuania, Slovakia, Poland and Romania.



## 4. SUMMARY FROM CASE STUDIES

### KEY FINDINGS

- All case study countries have a fairly long tradition of providing some form of sexual education to young people.
- Socially conservative resistance to SRE should be seen as a recently emerging (or resurging) trend in some countries.
- There are ongoing concerns in all case study countries about young people's sexual health and emotional well-being.
- There are ongoing concerns in all case study countries about violence and abuse within intimate relationships, young people's exposure to online risks and increasing levels of some sexually transmitted infections (STI).
- According to all NGO, teachers and SRE providers, SRE should be taught in schools as part of a wider well-being and health context.
- In all case study countries, there was no regulation of the content of SRE lessons or the number of hours that pupils should spend on SRE.
- SRE provision in all case study countries is or could be inconsistent due to the lack of government regulation.
- There is a worrying lack of information and advice for LGBTI young people in the UK in particular, which is related to increased risk of STI transmission.
- There is reported to be a strong appetite for SRE among young people in all case studies and also among parents and teachers in the UK and Denmark.

### 4.1. Background and history of SRE in case study countries

All case study countries have a long tradition of providing some form of sexual education to young people. The histories of the sexual education of young people in the case study countries are characterized by opposition between those who wish to provide some form of sexual education, mainly for reasons to do with disease prevention, and those who resist providing SRE completely.

Broadly, however, following the social revolutions of the 1960s and 1970s, reforms to and increases in the provision of SRE were implemented in all three countries (Denmark, the UK, Spain). Laws governing SRE first introduced in the 1970s generally focused on disease prevention and biological elements. It is not until the 1990s that case study countries introduced laws making it mandatory to provide some form of sexual education as part of a wider health and well-being teaching strategy. In the 1990s in all case study countries, there was fairly vocal socially conservative public and media opposition to these changes.

The school system in all case study countries involves, to a large extent, devolution of authority either to the local administrative body or to schools themselves. In the UK, for example, recent changes to education policy have introduced Academies and Free Schools, which are paid a grant directly from Government to provide education and are given relatively high levels of autonomy over teaching methods, subjects and school entrance policies. In Denmark, schools have similar levels of autonomy as UK Academy and Free Schools and are governed by a set of common objectives for pupils' learning, rather than prescribed lesson

plans or formats. In Spain, local government and regional authorities are responsible for funding SRE. The heterogeneity of schools within these governance arrangements presents a number of challenges for the provision of SRE, which are discussed in subsequent sections.

## **4.2. Sexual, reproductive and relationship health**

There are ongoing concerns within all case study countries about young people's sexual health and emotional well-being which, according to interview respondents, highlight the pressing need for good quality SRE. One common concern is about levels of abuse and violence that occur within intimate relationships between young people. In the UK, for example, a study conducted in 2009 found that over half of young women aged 18 to 21 years reported experiencing at least one abusive incident from a boyfriend, husband or partner in a survey conducted by a domestic abuse charity (Refuge, 2009). Another study found that one in five young men harboured extremely negative attitudes towards women in the UK (Barter and Stanley, 2009). In Denmark, according to a 2008 population survey of young people aged 16-24 who have had 'dating' experience, 12% of young women and 5% of young men reported having been victims of psychological, sexual and/or physical dating violence (Schütt et al, 2008).

In all case study countries, conception rates among young women aged 15 to 19 years increased in the decade up to the mid-2000s and from that point have declined significantly. For example, in the UK, this decline was widely attributed to the Teenage Pregnancy Strategy in 1999, a nationally coordinated and well-funded strategy which involved health, social services and education, to reduce levels of conception among young women. Rates of STIs appear to be steady in Spain. However, in the UK and Denmark rates of gonorrhoea and syphilis have increased markedly in the 15 to 24 age group between 2008 and 2012/13. In Denmark, condom use at first sexual intercourse was recorded by 69.9% of women and 62.3% of men aged 15-29 in 2012, leaving a significant minority who did not use condoms (Jørgensen et al, 2015). In the UK, approximately 80 per cent of people aged 16 to 24 years said they had used a condom when they first had sex (FPA, 2011). However, in younger age groups this rate was significantly lower, with 31 per cent of men and 33.6 per cent of women reporting they did not use condoms at first sexual intercourse.

## **4.3. Current provision of SRE**

According to all NGOs and some other respondents, SRE should be taught in schools as part of a wider well-being and health context.

In all case study countries, SRE is ostensibly taught within an overall health and well-being framework. However, the extent to which SRE is actually delivered in this way causes many interview respondents concern, in all case studies. For example, in the UK, the Government department responsible for education 'recommends that sex and relationship education is delivered through the PSHE and Citizenship framework' (DfE, 2000). However, this recommendation is not enforced through the National Curriculum (DfE, 2014). In Spain, schools may choose whether or not to implement SRE; they may choose their approach to and the scope of SRE lessons, as well as the length of the programme and the age range of SRE participants. Denmark, however, manages schools' implementation of SRE differently in that its curriculum is established through Common Objectives for the education of children. Schools are obliged to fulfil these Common Objectives for their students' education. Importantly, there are a number of components within the Common Objectives that address SRE directly and, therefore, shape the way that teachers approach the subject. The Common Objectives relating to SRE teaching in Denmark concern 'Health and Wellbeing' and 'Gender,



Body and Sexuality'. Thus, schools maintain autonomy over lesson planning and approaches, but learning outcomes specific to SRE are to an extent centrally regulated.

Respondents indicated a number of ways in which young people are educated about sexuality outside of schools. The media and internet were viewed as increasingly important channels for SRE education. This was seen both as an opportunity to improve young people's knowledge and also as a concern, as young people may develop unrealistic or unhealthy expectations about sexual activity from pornography and may also be made vulnerable to sexual exploitation.

#### **4.4. Challenges for SRE in case study countries**

The main and common challenge in all case study countries is largely a political challenge. Whilst parents, teachers and pupils have expressed a desire for better SRE in school, Governments have not legislated to make its provision compulsory. This system has resulted in SRE provision that is inconsistent quality and quantity.

All case study countries have devolved education systems by which local authorities or schools are able to set their approach to SRE. However, particularly in the UK and Spain, as it is not a statutory subject, SRE is frequently neglected in favour of other subjects. In Spain, the neglect of SRE was reported by respondents to be a result of individual schools' characters, philosophies and beliefs. In the UK, inconsistency was felt to be a result of teachers' pressure to achieve good exam results in core subjects. Whilst respondents in Denmark also expressed concern about the potential for neglect of SRE within their system, the curriculum structure and SRE's place within it largely protects against this risk, for the time being.

All respondents in all case study countries reported that the quality of teaching of SRE was highly variable or was at risk of being so. This was felt to be due to a lack of suitably trained teachers or compulsion for teachers to undergo training. In Denmark for example, student teachers are not obliged to take courses in teaching SRE. In the UK, the government inspector of schools, Ofsted, found that sex and relationships education required improvement in over a third of schools in England in 2013 (Ofsted, 2013).

A particular criticism voiced by the UK respondents was the lack of LGBTI-focused material and discussion within SRE. As well as failing to address the needs of LGBTI young people, according to a recent survey of young men who are attracted to men, many were unaware of how HIV is transmitted.

#### **4.5. Opportunities and future developments of SRE**

An important opportunity reported across all case study countries is that there is a strong appetite amongst young people for good quality SRE. Young people are reported to be very engaged and responsive to good quality SRE where it is provided. Teachers and parents are also reported to be supportive of SRE provision in schools in the UK and Denmark. This means that political will could be developed to improve the consistency of SRE provision across schools with careful campaigning.

In the UK, NGOs and educators are lobbying government for changes in the law to make SRE a compulsory and regulated subject. In one example, an NGO is working with a group of young people aged between 16 and 25 to research the demand for SRE and present their findings to government. It is hoped that this approach will persuade legislators to make SRE statutory. Denmark has secured political will and cooperation (albeit not perfect) through different means. Here, an important NGO worked aside government officials to research and

plan learning materials and guidelines for the teaching of SRE. They also co-designed the series of learning goals 'Common Objectives' relating to SRE. This arrangement appears to ensure both school autonomy as well as ensuring good quality SRE advice and information is disseminated. Whilst there are risks to this model, the presence of a generally supportive and liberally minded population and media means that there is a high take up of these materials. This is less true in the UK and Spain however.

Another key opportunity for SRE in all three case study countries is the presence of an active and informed NGO sector in the field of SRE. These work within health promotion and disease prevention as well as positive rights and well-being approaches. The NGOs have developed their own materials and research into what young people want from SRE and how best to teach it. However, their materials and knowledge are only taken up on a voluntary basis in all cases.

## 5. CASE STUDIES

### 5.1. Denmark

#### 5.1.1. Introduction

In addition to a literature review and analysis of available data, interviews and correspondence were conducted with representatives of Sex & Society (Danish: Sex & Samfund), a non-profit organisation responsible for providing the reproductive health and education in the country, as well as another respondent working in a relevant Government Ministry.

#### 5.1.2. Background and history

Denmark has been a pioneer of Sexual Education since the 1930s and has been providing sexuality education since the 1900s. Historically, sexuality education in Denmark has been to encourage children to behave (or not behave) in prescribed ways, with a view to preventing sexually transmitted infection. However, this approach has broadened in more recent decades (Sex and Society, 2010). Since 1970 sexual education has been a compulsory part of the Danish school curriculum when the Danish Curriculum Committee provided guidelines on what should and should not be taught. The guidelines forbade educators to instruct or counsel young people about sex or sexual technique as well as 'erotic material'. There was some organised opposition to the compulsory nature of sexuality education from parents in 1976 (SAFE, 2006). Since 1991, there has been a curriculum for sexuality education published by Danish Ministry of Education, in which sexuality education was integrated as part of Human Health.

#### 5.1.3. Sexual, reproductive and relationship health

Denmark has a generally liberal approach to sexual and reproductive health and rights (SAFE, 2006). Abortion was legalized in 1973 following which, the legal abortion rate (the rate of abortions per 1000 women) reached a high in 1975 for women aged 15-49 and has declined almost constantly ever since (Hansen et al 2009). In 2014, the abortion rate for young women aged 15-19 was 12 per 1000; in 2006 the rate was 13.8. The live birth rate for young women aged 15-17 was 1.1 per 1000 in 2014, compared to 1.9 in 2004 (ONS, 2016).

Condom use at first sexual intercourse was reported by 69.9% of women and 62.3% of men, according to a random sample population survey of young people aged 15-29 conducted in 2012 (Jørgensen et al, 2015). This leaves a significant minority who did not use condoms at first sexual intercourse. According to the same survey, the mean age at first sexual intercourse was 16, with the majority reporting being aged 14-18 at first sexual intercourse (ibid, 2015). The majority of respondents reported having one sexual partner in the last 12 months (62.4%), with 29% reporting having had 2-5 different sexual partners. According to a 2008 population survey of young people aged 16-24 who have had 'dating' experience, 12% of young women and 5% of the young men reported having been victims of psychological, sexual and/or physical dating violence (Schütt et al, 2008). From this the authors estimate that around 28,000 women and 12,000 men aged between 16-24 years are victims of intimate partner violence each year in Denmark. In 2006, a telephone survey of 3552 women found that 50% of women had experienced physical or sexual violence, or threat from a partner since the age of 16 (Balvig and Kyvsgaard, 2006). Similarly, the FRA Survey (2013) found that in Denmark 55% of women have experienced physical and/or violence or threat from partner or non-partner since the age of 15. The same survey also pinpoints that 18% of women in Denmark has faced 'cyberharassment' in the 12 months before the survey, the highest prevalence rates across Member States.

#### 5.1.4. Current provision of SRE

Whilst Danish schools have relative autonomy to set their lesson plans they are guided by Common Objectives, set by the Government, about what skills and knowledge young people should acquire at different ages up to the ninth grade (age 14-15). Sexuality Education is addressed across two of these Common Objectives. According to NGO interview respondents, these Common Objectives are generally felt to be helpful and 'progressive'. The Common Objectives allow teachers to set their own approach about how young people will achieve the objectives, thus, they may be addressed in any lesson or subject from Maths to Sociology, although in practice, some subjects are more amenable to the SRE related Common Objectives. The Common Objectives were set in consultation with the Danish Family Planning Association, Sex & Samfund (Sex & Society), which also provides online materials and advice to teachers and pupils about how to provide SRE ([www.sexogsamfund.dk/sex-samfund/om-sex-samfund.aspx](http://www.sexogsamfund.dk/sex-samfund/om-sex-samfund.aspx)). The end objective of for 9<sup>th</sup> grade pupils is that 'The subject should contribute to the prerequisites of the pupils' abilities to jointly as well as individually commit to actions that promote the health of themselves and others.' A range of topic areas are covered in the online materials available for teachers to use in lessons. These are divided across Health and Wellbeing subjects ('sexual health, Personal boundaries, Relationships, Rights for children, feelings, lifestyle and living conditions') and 'Gender, Body and Sexuality' ('Sexual rights, Norms and ideals, Body, Reproduction, Puberty'). Guidance material provided by the Sex & Samfund covers a wide range of issues including lesbian, gay, bisexual and transgender identities, consent and respect, digital media and remaining safe.

#### 5.1.5. Challenges for SRE in Denmark

The main challenge for SRE in Denmark is that whilst it is compulsory to provide health and sexuality education, it is not defined as a specific subject and neither are there a specific number of hours that must be dedicated to it. Each individual school is able to set their own approach to how the Common Objectives for SRE are taught. Whilst interview respondents felt that schools and teachers are generally willing to provide good quality SRE, it is also an acknowledged risk that provision will be '*heterogeneous*', according to one NGO respondent, and some students may not access the education they need. In particular, schools are not obliged to provide SRE at given times or hours, meaning that it is possible for SRE to be taught in a short space of time, to fit around other curriculum obligations. Interview respondents noted that teachers have many responsibilities towards their pupils' education and there is an inherent tension between other curriculum duties and delivering the Common Objectives on SRE. According to interview respondents, this tension is greater for older pupils, past grade 9 when they are not covered by the SRE Common Objectives. At this stage, pupils and student take important academic exams and as a result, teaching time may be more protected and teachers less inclined to find time for SRE, yet this is also the stage, arguably, when young people are most in need as it is a time of sexual research and first dating experiences.

Teachers in training are not obliged to take up modules on how to teach SRE, although teaching colleges are obliged to provide these modules. This means that some newly qualified teachers may have no training in providing SRE.

Whilst there is an official Government body for monitoring whether Common Objectives are being met in schools, there is no formal examination or other set of standards for ensuring that good quality SRE has being delivered. This is a weakness of the system according to an NGO respondent and means that there is a lack of information about the time spent, materials used and pupil responses to SRE being provided. Furthermore, the impact of SRE on pupils is under-researched in Denmark, it was reported.

### 5.1.6. Opportunities and future developments

According to all interview respondents, there is broad support within the public, pupils and teachers towards compulsory sex education in schools. This is reflected each year when Sex & Samfund coordinate their annual 'Week six' programme, which is supported by a dedicated website with free guidance and materials for pupils and teachers. Week six was developed after extensive consultation by Sex & Samfund with teachers, parents and pupils in 2005 about what SRE is and what should be provided in schools. Findings from this consultation were developed into materials for 'Week six'. This is a week of Sexuality Education offered to pupils and students during one week in February. It is a voluntary programme. In 2016, over 500,000 young people and 12,000 teachers took part in week six, according to Sex & Samfund. The programme covers a range of subjects geared towards different age groups. There are a wide set of materials and guidance about what and how to teach. For very young pupils in grades 0-3 (ages 3 to 6 years old) subjects include the 'body, boundaries, sex, emotions and family: What does it mean to feel good and what needs to be done, that we are healthy and feel good with our friends and family' (Week 6 website, 2016). For grades 4-6 (ages 7 to 9) courses cover 'identity, puberty, sex, emotions, families and the media' and, for grades 7-10 (ages 10-12) courses cover 'disease prevention, pregnancy and sexuality' (ibid, 2016).

An area of growing concern and being increasingly addressed by Sex & Samfund is the risk posed to young people by digital and online media, pornography and forums. Both Government and NGOs are keen to address these risks within available teaching guidance.

NGO respondents reported that the media in Denmark, as well as the public, are generally supportive of progressive sexual education and there is little resistance to young people being taught on a wide variety of subjects. Furthermore, teachers, schools and pupils have a healthy appetite for sexuality education. This has rendered it unnecessary, according to a NGO respondent, to tighten laws on SRE, for example, by stipulating the amount of time spent and lesson plans for delivering SRE.

## 5.2. Spain

### 5.2.1. Introduction

In addition to a literature review and analysis of available data, interviews were conducted with representatives of two NGOs.

### 5.2.2. Background and history

Cultural associations and organisations such as the Feminist League for Social Education and Abolitionist Society began providing sexual information and advice in the 1920s. When the Second Republic was founded in the 1930s it implemented sexual information and advice programmes across the country, especially in urban areas. These were largely concerned with biological and medical issues. However, after the Spanish Civil war, the Catholic Church, strongly linked to the dictatorship, took on a greater role in regulating private life and adopted a religion-based moral approach to sexual issues.

1970 is usually highlighted as the starting point for sexual and health education policies in Spain. The regime's educational model shifted from its catholic, nationalistic and technocratic model to more European approaches. Nevertheless, the Education Law's (LGE) sexual education programme only covered issues relating to reproduction and anatomy. In essence, this programme aimed to prevent risk associated to sexually transmitted infections rather than a holistic approach to sexuality and well-being.

After decades of dictatorship, the first democratic government of the Union of the Democratic Centre (UCD) party (centre-right) drafted an educational law (LOECE) in 1981, which aimed to implement a sex education programme. However, this was never implemented due to the resignation of the first elected president and the attempted 'coup d'état' in February 1981. Thereby, SRE was not implemented until 1990 when the Socialist Party (PSOE) substituted the outdated educational framework from 1970 for the new education law (LOGSE). This was the first attempt to include a cross-curricular sexual and health education programme, whose content was taught in different disciplines ranging from social to natural sciences. However, these policies were not consistently implemented as schools had a high degree of autonomy.

In 2002 the Government at the time, relegated sexual education to health sciences with the LOECE bill. Reproductive discourse and sexual education was seen only in biological terms and emotional, relational and affective aspects were neglected. This was a highly controversial move and school professionals, sexual health experts and trades unions objected. A change in government in 2004 and the new education law (LOE) in 2005 introduced a new SRE programme that covered issues such as gender violence, sexism and sexual diversity. SRE became cross-curricular again in three subjects: physical education, natural sciences and citizenship education. This programme put affection, identity, sexual desire and gender balance in the centre of the debate in schools.

However, in 2011 the new Government introduced a new educational bill (LOMCE) in 2012. This removed the sexual-affective approach of the 2005 programme and also removed from the school's curriculum the 'citizenship education' module. This made SRE similar to the approach taken in the 1970's.

### 5.2.3. Sexual, reproductive and relationship health

The fertility rate per 1000 women (aged between 15 to 19 years old) increased in Spain between 1995 and 2007 reaching a maximum of 12.7% in 2007 (UN, 2015). Since 2007, levels began to decline and according to the latest data available in 2014, the rate per 1000 women was 8.52 (World Bank, 2014).

According to INE (2016) data for all age groups, live births in Spain have decreased since 2007 from 11.4% to 9% in 2015. In the period from 1997 to 2006, live births increased significantly since from 9.2% up to 11.4% (INE, 2016). Similarly, according to ONS data from 2016, live births for under 18 years old women decreased from 4.8% in 2013 to 4.6% in 2014. Simultaneously, the total number of abortions in Spain has declined (MSSSI, 2016) since 2011. Latest available data show that abortion rates have significantly declined in women under 19 years old from 13.68% in 2011 to 9.92% in 2014 (MSSSI, 2016). A number of demographic reasons explain this decline in live births and abortions, such as emigration and population ageing. However, the impact of a restriction on abortion introduced in 2015 (requiring women under 17 to get parental consent for abortion) cannot be ignored. This means that data on abortions amongst those under age 17, without parental consent are not available.

Rates of diagnoses of sexually transmitted infections amongst the 15-19 age group have been below 1% since 2007. Similarly, rates of diagnoses of sexually transmitted infection amongst the 20-24 age group have been oscillating between 2 and 3 per cent in the period 2007-2014. Overall, rates of STI's are at a standstill in Spain, however, NGOs are concerned with risky behaviours in specific groups such as young and LGBTI people.

In 2015 Spain raised the minimum marrying with consent age from 14 to 16 years. Until then, Spain had the lowest marrying age in the EU-28. The marriage rate for the age group between 15 to 19 years in 2015 is slightly below 2% whereas in 2000 this age group accounted for a little more than 9% (INE, 2016).



According to recent data, 2.9 per 1000 women aged under 19 have been victims of domestic violence and 2.6 per 1000 aged between 20 and 24 (INE, 2014). NGO respondents raised concerns that domestic and gender violence is spreading amongst youngsters in schools and facilitated through social media platforms.

Similarly, the FRA Survey (2014) found that in Spain, 22% of women have experienced physical and/or sexual violence, including current or previous partners. 4% of women stated to have experienced physical and/or sexual violence by any partner in the 12 months before the FRA survey. Moreover, according to FRA data, 33% of women experienced psychological violence during the relationship. The same survey also found that 10% of women in Spain have faced 'cyberharassment' since the age of 15.

#### 5.2.4. Current provision of SRE

Although sexual and relationship health education is not a priority for the current Spanish Government, according to NGO respondents, there are several organisations providing SRE advice, materials and support. This includes Red Cross Youth and Family Planning Centres. However, the implementation of SRE programmes depends on school's willingness, as schools have autonomy to choose their approach to SRE and its scope, the length of the programme and the age range of SRE participants. Although SRE content is mainly provided in schools, teenagers can also receive sexual and health information in Family Planning centres. Red Cross Youth undertake outreach work to meet young people outside of schools and during weekends to inform them.

Another feature of the Spanish case is the diversity of schools and their implementation of SRE. As one NGO respondent reports *'Unlike what people believe, there is not a huge difference between public schools (state funded) and private schools in terms of SRE. Sometimes you find private or religious schools that want to implement a more comprehensive SRE programme and public schools that provide no SRE whatsoever'*. This is, according to the same respondent *'because SRE relies on the head teacher's willingness, thus being their personal beliefs [to bear]. [Also], budgeting goals are the main burden for developing a consistent SRE programme'*.

Although administrative bodies such as the Autonomous Communities (CCAA) and Local Governments do not have full legislative power regarding Education and Health, they can provide discretionary funding for SRE programmes. This reinforces differences not only across territories but also between rural and urban areas. According to one respondent from the Family Planning Association Madrid (APFM) *'the demand is that high and our resources that limited that we can only deal with workshops in the city area, leaving some other regions of the CCAA unattended'*.

Sexual and health education programmes provided by Red Cross Youth and the Family Planning centres cover a wide range of topics including risk and prevention of STIs, contraception, drug and alcohol use, gender and domestic violence, sexual identity, emotions and relationships management, etc.

#### 5.2.5. Challenges for SRE in Spain

Currently, sexual and health education in Spain is not high on the political agenda, according to NGO respondents. Despite evidence to the contrary, some influencers such as the Catholic Church and within the Conservative Party believe that there is a direct link between sexual education and increases in sexual practices and pregnancies amongst young people. In Spain, there is also a longstanding political belief that families and communities, rather than the state, should regulate intimate life. Moreover, the media frequently portrays young people and LGBTI groups as risk taking. These elements make it difficult to argue for investment and support for comprehensive SRE, according to NGO respondents.

The main sources of sexual, health and relationships information in Spain are peers, media and internet and, in some cases family, which can mislead young people. As one respondent from the NGO stated *'we have the feeling that we arrive late, girls and boys have had previously contact with sexual information and content such as porn, which portrays a distorted idea of what they will encounter in real life'*.

There is an absence of standardised national guidelines, a lack of professionals to provide SRE, a lack of teacher training and a lack of funding for SRE programmes. One NGO respondent reported that their organisation relies mainly on volunteers who come from very different professional backgrounds. Whilst there is some government-derived funding available for one NGOs, it is felt to be inadequate and the organisation must rely on donation funding. Furthermore, it was reported that some schools rely on hygiene companies to provide SRE but this is done often in insufficient ways such as workshops on how to use their products (e.g. condoms, tampons).

#### 5.2.6. Opportunities and future developments

According to NGO respondents, young people demonstrate an appetite for learning about SRE and respond very positively in workshops and programmes.

Organisations delivering SRE in Spain are already delivering interesting content through digital platforms. These materials are diverse. For example, one NGO interviewed provide material on sexual health and behaviour but also participation, gender perspectives, development, environment and sustainability. This shows that if these subjects cannot be taught in school hours, technology could provide a means to bring it to young people outside of school.

### 5.3. United Kingdom

#### 5.3.1. Introduction

In addition to a literature review, interviews were conducted with representatives of two Non-Governmental Associations working in the field of sexual and reproductive health and education as well as a respondent working within the education legislative process.

#### 5.3.2. Background and history

Educating children and young people at school about sexuality has been legislated for in England and Wales since the 1986 Education Act, which required all state-funded schools to have a sexuality education policy in place. Whilst biological aspects of sexuality have been taught within the Science curriculum since 1993, from the early 2000s, in England and Wales, sexuality education has been within the remit of 'personal, social and health' education (PHSE).

Under the Education Act (2002) and Academies Act (2010), government funded schools have a statutory duty to promote children and young people's well-being which includes promoting the 'spiritual, moral, cultural, mental and physical development of pupils at the school' (Secretary of State for Education, 2015). Further, all state funded schools have a statutory duty to provide sex and relationships education as part of the basic curriculum. However, importantly, parents are able to withdraw their children from any aspect of SRE, except for the elements that are taught within the Science National Curriculum (biological components). Crucially, Private, Academy and Free Schools (new types of schools that are state funded by managed through devolved powers by parents, faith groups or others) are not subject to the same statutory duties as other state-funded schools and do not have to provide SRE except for that covered within the science curriculum. Academies and free schools constitute approximately 18% of all primary schools and 65% of secondary schools (DfE, 2016), thus



a majority of schools are not statutorily obliged to provide PHSE or SRE. Moreover, there is no minimum amount of time that pupils are required to spend on either PHSE or SRE. In 2015 the UK Government refused to make PHSE and SRE compulsory for all pupils in England and Wales, despite strong recommendations to do so from the standing Education Committee, a cross-party committee of members of parliament (Education Committee, 2015).

### 5.3.3. Sexual, reproductive and relationship health

In 1998 the UK had one of the highest rates of conception to women aged 18 or under in Western Europe. However, this rate halved between 1999 and 2013. In 2014 (the latest data) the under 18 conception rate was the lowest since 1969. This decline has been attributed to a sustained Government programme (the National Teenage Pregnancy Strategy) to reduce the under 18 conception rate. This involved 'high quality education about sex and relationships in schools' combined with access to good quality health and contraception advice and cross-coordination between government agencies (Wellings et al, 2016). Amongst the 15-24 age group, rates of diagnoses of sexually transmitted infection in England have risen considerably in the five years to 2015 (Health Protection England, 2015). The average age at first intercourse was reported as 16 for both men and women in survey conducted by the Family Planning Association, 2009. 30 per cent of men and a 26 per cent of women aged 16-19 first had sexual intercourse before the age of 16 (FPA, 2011).

According to ONS data from 2016, live births from women under 18 years old, decreased in the UK from 8.0% in 2013 to 6.8% in 2014.

Researchers have long been concerned about the level of tolerance towards and experience of abuse by intimate partners amongst young people. For example, in 2009 over half of young women aged 18-21 reported experiencing at least one abusive incident from a boyfriend, husband or partner in a survey conducted by a domestic abuse charity (Refuge, 2009). Research conducted by Barter and Stanley (2009) also found that more than four in ten girls aged 13-17 in England have experienced sexual coercion. The research also found that one in five young men harboured extremely negative attitudes towards women (Barter and Stanley, 2009).

The FRA Survey (2014) found that in the UK, 44% of women have experienced physical and/or sexual violence, including current or previous partners since the age of 15. According to the same FRA data, 8% of women claimed to have experienced physical and/or sexual violence by any partner in the 12 months before the FRA survey. Furthermore, 46% of women experienced psychological violence during the relationship. The same FRA survey also found that 13% of women in the UK have faced 'cyberharassment' since the age of 15.

### 5.3.4. Current provision of SRE

PHSE covers a wide range of potential subjects including sexual behaviour and sexual health, drug and alcohol use, violence against women and girls. All schools that provide PHSE and SRE must 'have regard to' statutory government guidance on what content should be provided. The guidance was published in 2000. This states that 'sex and relationship education is to help and support young people through their physical, emotional and moral development' and SRE should be part of wider PHSE teaching which is intended to 'help pupils develop the skills and understanding they need to live confident, healthy and independent lives' (Department for Education and Employment, 2000). The Department for Education 'recommends that sex and relationship education is delivered through the PSHE and Citizenship framework', however, this recommendation is not formally enforced.

### 5.3.5. Challenges for SRE in the UK

According to NGO respondents, the quality of SRE provision in schools across the UK is very varied owing to the differences between school types and their curriculum obligations. Moreover, according to one NGO respondent, guidance about the provision of SRE in schools, which schools must refer to in providing SRE is 'outdated and is not fit for purpose'. Inconsistent quality of SRE provision is exacerbated, according to NGO respondents, because many teachers are not provided specialist training and support with delivery. According to one, *'we find with HIV teaching is only through biological facts in science lessons. Young people often aren't taught about HIV or other STIs in a context which may be applicable to them'*. According to a survey of young men attracted to other men in 2015, 33% had been taught about how HIV is passed on and how to have safer sex. 68% had not received information, advice or support on HIV testing. According to the NGO respondent, *'this is simply not good enough and puts young men at greater risk'*. Moreover, according to the same respondent, *'a lot of sex and relationships education is highly heteronormative and ignores the needs of LGBTI young people. Schools don't have to teach about same-sex relationships, and without support many teachers struggle to broach this subject and to answer questions'*.

A recent report by the official school inspector reported that learning in PSHE required improvement or was inadequate in 40% of schools, and that sex and relationships education required improvement in over a third of schools in England (Ofsted, 2013). However, a key challenge for PHSE and SRE in England and Wales is lack of political appetite to regulate it, according to a number of respondents. A 2015 report by a cross-party committee of Members of Parliament (MPs) produced a number of findings on PHSE and SRE, following extensive consultation with educators, sexual health professional and parents. Chief amongst these was that provision varied in quantity and quality across the country, that the provision of SRE was necessary to improve sexual health and well-being amongst young people and that the quality of SRE providers should be improved. Crucially, the report recommended that PHSE and SRE be made statutory so that all pupils received the same level of education. However, these recommendations have largely been rejected by Government.

There is a tension between a long-standing political agenda to protect individual, family and community 'freedom' in many aspects of public life and to 'minimise' government, according to all respondents. The recent drive to give schools greater freedoms through the Academy and Free school movement is part of this approach. According to interview respondents, this has hampered efforts to give SRE and PHSE a protected status in the way that other curriculum subjects such as Mathematics and English have. Moreover, the presence of a socially conservative press in the UK discourages politicians from making changes to SRE provision, particularly in a liberal direction, according to both NGO and legislative respondents.

As schools are under increasing pressure to deliver lessons and good exam results in statutory subjects, schools may neglect SRE or PHSE in order to prioritise the other subjects. According to one respondent, *'Government are worried that if they protect SRE in the same way as Maths or English, they would get calls from lots of other advocates to protect their subject too'*. Owing to the lack of protected status, according to all interview respondents, many schools provide SRE and PHSE in one session at the end of the school year, a practice that is heavily criticised by both sexual health professionals and leading educators. According to a number of respondents the quality and training of teachers or those who are delivering SRE is also inconsistent and poor in many respects.

Interview respondents highlighted the need for improved advice and support to young people to protect them from the dangers of sexual or other exploitation online. Respondents pointed out that young people are now exposed to a wide range of media including online forums,

digital messaging and websites where they are exposed to sexual images and ideas that they will not be equipped to understand.

Whilst the national Teenage Pregnancy Strategy was perceived widely as a success it has now ceased and has not been replaced. Furthermore, as with many health and social care services, services for young people are facing funding reductions (SAFE 2, 2012).

#### 5.3.6. Opportunities and future developments

There are growing calls to Government to improve the quality and quantity of PHSE and SRE provided to children and young people. In the short term, Government has promised to review the statutory guidance that informs SRE and PHSE provision. Whilst there remains the ability of parents to withdraw their children from almost all aspects of SRE, most parents are strongly supportive of the idea that schools should provide it to their children. In 2014 a group of NGO SRE educators and advocates developed supplementary advice on teaching SRE in schools, which also referred to the importance of LGBTI-inclusive SRE. However, whilst the Government welcomed this advice, according to one NGO respondent, schools are under no obligation to follow the guidance.

The risk posed to young people by digital and online media, pornography and forums is of growing concern to Government and SRE educators. It is likely that this area will be the focus for SRE education policy in the future and strengthens calls for revisiting statutory guidance on SRE.

Agencies such as the Family Planning Association are involved in training teachers to deliver better SRE and provide guidance to teachers online. One strategy a sex and relationship health NGO is about to deploy is to work with young people (aged 18-25) to explore what components of SRE should be made statutory. They will then present their findings to Government. It is hoped that this will boost political will and public support for reforms to the SRE and PHSE system.

## 6. CONCLUSIONS AND RECOMMENDATIONS

### Conclusions

This study sought to explore and update knowledge on the provision of sexual education and reproductive rights in the European Union. It identified a clear consensus from international organisations as well as NGOs, educators and professionals operating in the case study counties about what SRE should involve, its content, its importance and necessity.

The study also found clear evidence of the need for effective SRE. Rates of sexually transmitted infections are increasing in Europe, particularly amongst young people. Rates of intimate partner abuse are also high amongst young people in Europe. There are increasing concerns about children and young people being exposed to risk of sexual exploitation and inappropriate sexual norms and behaviours through online and social media and pornography. These hazards are all countered through effective SRE.

Importantly, SRE is considered to be most effective at reducing risks of disease, interpersonal abuse and promoting well-being if it is introduced as part of a positive and rights based framework which emphasises personal choice, is non-judgmental and seeks to empower people to make choices about their sexual life. Further, the provision of SRE is mandated through various conventions to which Member States are signatory, notably the Convention on the Elimination of Violence Against Women (CEDAW) and the Convention on the Rights of the Child (CRC).

In all case study countries, interview respondents from NGOs and legislators also support the rights based approach to SRE. However, despite this, there is a clear failure of implementation in most countries. Even where some component of SRE is mandatory, its implementation appears to fall short of the recommendations of educators and specialists. This is due to lack of political will to enforce mandatory components of SRE, for example by allowing parents the ability to withdraw their children from SRE lessons or allowing schools strong autonomy in how they design lessons or allocate time for students. This is due to either perceived or actual public and media pressure and fears of moral panic that erroneously assumes that SRE increases in sexually transmitted infection and unplanned pregnancy. In fact, the reverse is true.

In Denmark, however, despite the autonomy left to schools to decide how to provide their students with SRE, there is widespread support and uptake of well-researched, positive rights-based materials. Voluntary uptake of a SRE week provided by an NGO has reached 500,000 pupils and 12,000 teachers. This, according to respondents, is likely due to the public holding progressive ideas around sex and relationships and a media that is also broadly supportive of this approach. This environment allows government, NGOs, teachers and pupils to work together in the design of SRE goals.

Implementation challenges continue to hamper efforts to provide good quality SRE. These include a lack of teacher training on SRE, lack of monitoring of students' SRE learning achievements and inconsistencies in the way that SRE is funded within countries.

## **Recommendations**

For the European Parliament and Commission:

- To strongly advise Member States to be consistent in their implementation of SRE, including recommendations about the minimum amount of time pupils spend on it.
- To monitor the implementation of SRE policies.
- To invest in research and monitoring of students' knowledge on SRE subjects.
- To invest in research to find a compelling evidence base for what young people want from SRE.
- To invest and support NGOs to research and refresh SRE teaching materials, including making such materials available online.

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## ANNEX

**Table 1: SRE provision and other indicators in the EU-28 Countries**

Country	National Legislation making SRE mandatory in schools	Date and name of relevant legislation/programme	Main providers of sexual education	Usual approach to sex and relationships education	LGBTI issues addressed in SRE curriculum	Gender- based violence addressed in SRE curriculum	Marriageable age with parental consent (Groom/Bride) <sup>1</sup>	Marriageable age without parental consent (Groom/Bride) <sup>2</sup>	Same-sex marriage	Live Birth Rate age <19 <sup>3</sup>
<b>Austria</b>	Yes	1990 Integral Education principle 'Sex education in schools'.	Ministry of Education, Schools involving parents.	Sex education is seen as integral part of the whole education and should help children and young people to find their personal identity.	Yes	Yes	16/16 (the other partner must be 18 or older).	18/18	Some sort of same-sex union/civil partnership.	3.1
<b>Belgium</b>	Yes	1997	Schools have autonomy to decide the curriculum on SRE, calling upon guidance and resources from external organisations such as health organisations and the Family planning association.	Cross-curricular covering topics such as gender, intimacy, risk prevention and sexual orientation.	Yes	Yes	n/a	18/18	Legal. 2003	3.0
<b>Bulgaria</b>	No	n/a	SRE rely on schools, students and parents' choice with help of NGOS such as	Reproductive system, risk prevention, contraception and violence.	n/a	n/a	16/16	18/18	No legal same-sex unions of any kind.	35.5

			Bulgarian Youth Red Cross, BFPA and UNFPA.							
<b>Croatia</b>	No	n/a	Churches and parishes teach extracurricular programmes: Teen STAR and GROZD.	Religious views on sexuality and biology  Sexuality Teaching in the context of Adult Responsibility	n/a	n/a	16/16	18/18	Some sort of same-sex union/civil partnership.	4.3
<b>Cyprus</b>	Yes	2011	Ministry of Education and Culture, Schools and Cyprus Family Planning Association (CFPA).	Biological.	No	Yes	16/16	18/18	No legal same-sex unions of any kind	5* different source
<b>Czech Republic</b>	Yes	2010	Schools and Family Planning Associations.	Cross-curricular, taught in biology, Citizenship, and Family Education. It covers Contraception, risk and STI prevention.	Yes	No	16/16	18/18	Some sort of same-sex union/civil partnership.	5.3
<b>Denmark</b>	Yes	1970	Sex & Samfund (Sex and Society, the Danish Family Planning Association).	Integrates biologic with Relationships and affective.	Yes	Yes	15/15	18/18	Legal. 2012	1.1
<b>Estonia</b>	Yes	1996 (Updated in 2011)  Human studies in educational curriculum including SRE.	The Ministry of Education and Science and the Development Centre of the National Curriculum, Schools, Estonian Sexual Health Association and sexual and reproductive health centres.	Focuses on prevention and health sexuality education but also includes relationships.	No	No	15/15	18/18	Some sort of same-sex union/civil partnership.	6.7

<b>Finland</b>	Yes	2001 Sexuality education	National Board of Education, schools, teachers and experts.	SRE's approach evolves from biological on the lower grades to health and emotional education in upper grades.	Yes	Yes	n/a	18/18	Legal. 2017*	1.8
<b>France</b>	Yes	2001	Ministry of Education, schools, French Family Planning Movement and Haut Conseil à l'Egalité.	Biological, social and ethical aspects, affect, sexual identity and roles and sexism.	Yes	Yes	n/a	18	Legal. 2013	4.4
<b>Germany</b>	Yes	1992 Pregnancy and Family Assistance Act (SFHÄndG)	Regional governments implement SRE in schools.  National bodies such as Federal Centre for Health Education (BZgA), Elderly, Women and Youth (BMFSFJ), the Federal Ministry for Family, and the Federal Ministry for Health (BMG) are the main institutions in charge of policies.	Holistic approach: biologic, medical, emotions, ethics and relationships.	Yes	Yes	16/16	18/18	Some sort of same-sex union/civil partnership.	3.6
<b>Greece</b>	Yes	1995 Health Education Programme (Programmat a Agogis Ygeias)	In primary schools, teachers deliver the programme overseen by a regional Education Health director, who acts as a liaison between schools and the Ministry.  In secondary school, the SRE are offered outside the school programme by volunteer school teachers.	Biological aspects, anatomy and relational aspects	No	No	n/a	18/18	No legal same-sex unions of any kind	6.4

<b>Hungary</b>	No	n/a	Schools are advised to deliver the 'Sexual and Family Life' programme. School teachers and health care professionals deliver the programme.	Hygiene, sexuality education, sexual abuse and HIV/AIDS work, relationships.	n/a	n/a	16/16	18/18	Some sort of same-sex union/civil partnership.	15.4
<b>Ireland</b>	Yes Only at primary and post primary education.	2003 RSE	Schools decide what to include and exclude. Teachers deliver RSE. Secondary schools also rely on NGO's such as Irish Family Planning Association (IFPA) for workshops.  Parents can remove children from curriculum.	Biology, STI's, personal health and relationships.	Yes	Yes	n/a	18/18	Legal. 2015	3.2
<b>Italy</b>	No	n/a	Schools can provide SRE programme. Some schools rely on Family planning associations and NGO's.	Biological approach.	n/a	n/a	16/16	18/18	No legal same-sex unions of any kind.	2.4
<b>Latvia</b>	Yes	2007	Government provides policies but schools can decide what to teach.  NGO's such as The Latvian Association for Family Planning & Sexual Health (LAFPSH) and Papardes Zieds provide help on SRE.  Parents cannot withdraw children from this curriculum in primary school.	Biological and risk prevention.  Family, gender, relationships and pregnancy. Amendments in Education Law in 2015 requiring schools to provide 'morality education' is compromising freedom of expression and LGBT rights.	No	Yes	16/16	18/18	No legal same-sex unions of any kind.	8.9

<b>Lithuania</b>	No	n/a ban abortion	Schools and teachers bring their own view or rely on NGO's such as the Lithuanian Family Planning Association (FPSHA) or sexologist.	Risk prevention. The curriculum aims to discourage sex rather than explain the mechanics of sexuality and intimacy.	n/a	n/a	15/15	18/18	No legal same-sex unions of any kind.	6.1
<b>Luxembourg</b>	Yes	2006	Ministry of Health and schools.	Cross-curricular. SRE are taught in citizenship, biology and religion modules, covering a wide array of issues such as STI's, family, sex, drugs, relationships, pregnancy, etc.	Yes	Yes	n/a	18/18	Legal. 2015	2.4
<b>Malta</b>	Yes	1988 National Minimum Curriculum (NMC).	Ministry of education empowers schools to design their educational provision, including SRE.	The NMC aims to acquire: Education on Human Sexuality, Strengthening of Gender Equality and Wise Choices in the Field of Health.	No	No	n/a	16/16	Some sort of same-sex union/civil partnership.	6.5
<b>Netherlands</b>	Yes	2012	Ministry of Public Health is in charge of the policies with help of Ministry of Education.  Biology teachers, school doctors and NGO's help provide the SRE.	Comprehensive approach towards SRE including sexual development, reproduction, emotions and relationships.	Yes	Yes	16/16	18/18	Legal. 2001	1.3
<b>Poland</b>	Yes*	2009 <i>*Although 'Education for life' meant to be mandatory, they are non-existing.</i>	Parents choose whether children learn 'Education for life in the family' or not based in their beliefs. Schools and teachers can decide the content of this classes, making them inconsistent.	Biological. Knowledge considering sexual life, conscious and responsible parenthood, family values, life in prenatal phase, and methods of conscious procreation.	No	Yes.	n/a	18/18	No legal same-sex unions of any kind.	5.5

			Church also provides 'family life' classes.							
<b>Portugal</b>	Yes	2009	Ministry of Ed, Ministry of Health, Regional Education boards and the school boards, teachers and NGO's such the Portuguese Family Planning Association (APF).	Cross-curricular in several school subjects.  Comprehensive covering a wider health education programme including sexuality, nutrition, drugs and violence prevention.	Yes	Yes	16/16	18/18	Legal.  2010	5.3
<b>Romania</b>	No		Optional subject in schools 'Education for Health'.	Biological.	n/a	n/a	16/16	18/18	No legal same-sex unions of any kind.	29.2
<b>Slovakia</b>	No	1996	Parents and students' choice.  The state is responsible for the contents and implementation of education to sexual health as part of preparing children and youth for marriage and parenthood.	Cross-curricular included in ethics, religious education and biology, however these are optional classes.  There is a lack of information on STI's prevention, pregnancies and sexual identity.	n/a	n/a	n/a	16/16	No legal same-sex unions of any kind	15.9
<b>Slovenia</b>	Yes	2006	Schools.	Biological. Mainly about healthy life in first grade and then about contraception and reproduction in biology class.	No	No	15/15	18/18	Some sort of same-sex union/civil partnership.	2.0



<b>Spain</b>	No	n/a	School choice that rely on NGO's such as Young Red Cross and The Spanish Family Planning Association to deliver the programmes.	Focussed on anatomy and biological issues and then psychological and social aspects.	n/a	n/a	16/16	18/18	Legal. 2005	4.6
<b>Sweden</b>	Yes	2006 International Policy on reproductive Health and rights	The Swedish National Agency for Education, School's direction, teachers and NGO's such as The Swedish Association for Sexuality Education (RFSU) and the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Right.	Holistic approach.	Yes	Yes	n/a	18/18	Legal. 2009	1.5
<b>United Kingdom</b>	Yes*	2014 National curriculum (last update)  <i>*for Government funded schools only, Academies, private or Free Schools do not apply.</i>	Every school decides its programme and Personal, social, health and economic education (PSHE).  There are several organisation providing this service such as Family Planning Association (FPA).  Parents can withdraw children from SRE, except the biological components.	Only compulsory elements are biology components as part of science curriculum. Where additional SRE is provided it covers a broad range of subjects including healthy relationships, managing sexual consent, avoiding sexually transmitted infections.	No	No	16/16	18/18	Legal. 2014	6.8

<sup>1</sup> UN. (2014) Demographic Year Book. Table 23: Minimum legal age at which marriage can take place.

<sup>2</sup> Ibid. (2014).

<sup>3</sup> ONS. (2016) Live births women aged 'Under 18' and 'Under 20', (per 1,000 women aged 15 to 17 and 15 to 19) in EU28 countries, 2014.



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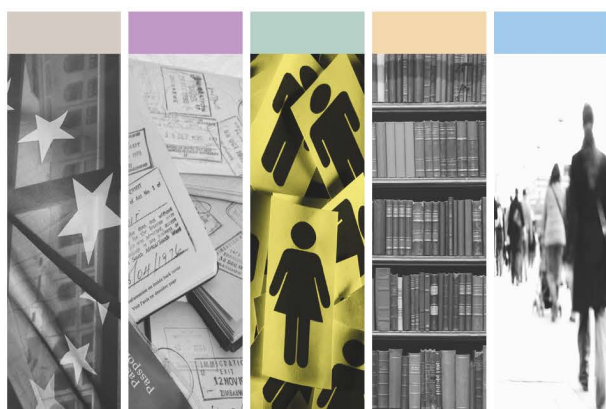
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