A SUMMARY OF EVIDENCE FOR RELATIONSHIPS, SEXUAL HEALTH AND PARENTHOOD (RSHP) EDUCATION IN SCHOOLS

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INTRODUCTION

To support and enhance delivery of the **Relationships, Sexual Health and Parenthood (RSHP)** curriculum work has been undertaken to identify, evaluate and summarise evidence of its impact.

Before exploring this evidence, some context.

Curriculum for Excellence is the national approach to learning and teaching for children and young people aged 3 to 18. The curriculum is grounded in values of wisdom, justice, compassion and integrity, and the human rights of all individuals.

Health and Wellbeing is one of eight curricular areas, its importance is reflected in its position at the centre of the curriculum and at the heart of children's learning. Along with Literacy and Numeracy, it is one of the three core areas that are the responsibility of all staff in learning establishments.

Learning in Health and Wellbeing is designed to ensure that children and young people aged 3 to 18 years old develop the knowledge and understanding, skills, capabilities and attributes which they need for mental, emotional, social and physical wellbeing. **RSHP is a key element of the Health and Wellbeing area of Curriculum for Excellence.**

Across the world there are different names for what, in Scotland, we call RSHP education. It might be called *sex education*, *relationship and sexuality education* or by United Nations bodies *comprehensive sexuality education*. These terms are used interchangeably in this paper, reflecting researchers own contexts and publications.

The United Nations identifies that a shared objective across national programmes is that they aim to ensure that all children and young people receive comprehensive, life skill based education that empowers children and young people with the knowledge, skills, attitudes to make informed, healthy and respectful choices about their relationships and sexuality.

Effective comprehensive sexuality education starts in childhood and progresses through adolescence and young adulthood, building knowledge and skills that are appropriate for each stage through a

carefully phased process over time, just like any other subject in the curriculum[1].

All children and young people have a right to an education that meets their needs. This will be enshrined in Scots law with impending incorporation of the United Nations Convention on the Rights of the Child (UNCRC). This educational entitlement includes opportunities to learn about relationships, sexual health and parenthood. From the *National Surveys of Sexual Attitudes and Lifestyles* (Natsal-3[2]) we know that school is consistently reported as the main source of information about RSHP topics for children and young people.

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[1] UNESCO (2015) Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education A Global Review. United Nations Educational, Scientific and Cultural Organization

[2] Natsal-3 is a multistage, clustered and stratified probability sample survey of 15,162 men and women aged 16–74 years, resident in Britain.

THE EVIDENCE FOR RSHP EDUCATION IN SCHOOLS

The areas listed below have been identified as those where there is evidence of the effect of RSHP education; each is discussed in this paper.

1. **The timing of initial sexual behaviour**
2. **The use of contraception and condoms**
3. **Conception and pregnancy**
4. **Sexually transmitted infections including HIV**
5. **Gender equality**
6. **Gender based violence**
7. **The prevention of childhood sexual abuse**
8. **LGBT inclusion**
9. **Children and young people with learning disabilities**
10. **RSHP education, wellbeing and attainment/achievement**
11. **The effects of RSHP education on knowledge, attitudes, skills and behaviour**
12. **Other factors that inform effectiveness of RSHP education:**
    - The timing of RSHP education: age, stage and progression as factors in effectiveness
    - Increasing effectiveness by connecting and engaging parents/carers with school based RSHP education
    - Learner engagement and active participation
    - The effect of RSHP education when it builds social emotional learning and media literacy
    - The effect of RSHP education when it is explicitly rights based
    - The effect of interactive digital interventions.

1. RSHP education and the timing of initial sexual behaviour

The timing of initial sexual behaviour is of importance because early experiences may be regretted and put young people at risk of harm, exploitation, STI or pregnancy. What we know about timing of initial sexual behaviour is described below, followed by some reflection on the impact that RSHP education can have.

From the National Surveys of Sexual Attitudes and Lifestyles (Natsal-3) we learn from participants interviewed between 2010 and 2012 that just under one-third of young people age 16 to 24 report that they had heterosexual intercourse before the age of 16.

Using data from a survey of schools in two local authorities, from young people in S3 to S6, NHS GGC (2016) report that LGB pupils were more likely than heterosexual pupils to have engaged in sexual intercourse (32% LGB; 21% heterosexual) or other sexual activity (41% LGB; 25% heterosexual). When asked to indicate how they felt about these experiences LGB pupils were more likely to say they were not ready for their first sexual experience (21% LGB; 15% heterosexual) or did not agree to their first sexual experience (7% LGB; 3% heterosexual).

Internationally, we know from a Norwegian study by Træen et al. (2016) that LGB young people are younger than their heterosexual counterparts regarding initial sexual behaviour. From Australia the work of Lyons et al. (2012) provides evidence of a strong link between age at first anal intercourse and infection with HIV/STIs, as well as tendencies to engage in higher risk sexual behaviour, meaning that efforts to delay sexual debut for gay and bisexual men could be protective.

Poobalan et al. (2009) in a review of reviews report that RSHP education does not increase sexual activity in young people, nor can it be associated with an earlier age of first intercourse. This is supported across the literature, for example in reviews by Kirby (2007), Owen (2010) and Lindberg (2011).

Using evidence from the aforementioned Natsal-3, Macdowall et al (2015) report that when school is cited by adults as having been the main source of sex education this is associated with later age at first sex.

Mueller et al. (2007) working with data from a US national survey report that receiving sex education was associated with abstaining from sexual intercourse, delaying initiation of sexual intercourse, and greater use of contraception at first sex; this was particularly so for population groups that are often considered the most disadvantaged.

Bourke et al. (2014) investigated the relationship between school sex education and sexual health behaviours at first sex and later in adulthood, using nationally representative data from Ireland. Results indicate that respondents who received sex education were more likely to have first sex at an older age and use contraception on this occasion. Sex education significantly increased the likelihood of using contraception at first sex when first sex occurred before 17 years of age. They conclude this supports the notion that sex education may be of particular importance for vulnerable subgroups that are at risk for early first sex.

Ramirez–Villalobos et al. (2021) evaluated a comprehensive sexuality education initiative for adolescents in public schools in Mexico and report that students who received information from teachers who were trained in delivery, delayed sexual debut and when they had sex were more likely to use contraceptive.

In a broader review of evidence Kirby et al. (2007) found that 42% of comprehensive sex education programmes examined significantly delayed the initiation of sex for at least 6 months. In work published in 2008 Kirby, reporting on a review of 48 studies, found that nearly half of these comprehensive programs delayed adolescents' initiation of sex, one in four reduced the frequency of sex, and nearly half reduced the number of sexual partners.

While the evidence presented above points to the impact that RSHP education can have on encouraging young people to delay having sex, it is worth noting that in their review of evidence, Oringanje et al. (2016) called for some degree of caution about claims, reporting that educational

interventions were unlikely to *significantly delay* the initiation of sexual intercourse among adolescents.

Although not a feature of RSHP education in Scotland, in a comprehensive review of reviews of school-based interventions to improve sexual health Denford et al (2017) find that abstinence-only interventions are found to be ineffective in promoting positive changes in sexual behaviour, including delay of initial sexual behaviour.

2. RSHP education and the use of contraception and condoms

With the intention to adopt a positive approach to young people's sexual health NHS Tayside/Make it Good (2016) undertook an insight gathering project that engaged young people in discussion of sexual health and relationships. Workshops with young people in S5/S6 (177 participants) and in community settings (60 participants) were followed by 930 contributions to a series on short online topic-based surveys. While condom use was associated with both contraception/birth control and STI prevention, the primary focus for young people was to use condoms to prevent pregnancy. The balance of responsibility for condom use and contraception was reported as sitting with young women; the report suggests that efforts could be made to teach and support adolescents to effectively communicate with partners to use condoms and to challenge norms that see young men making decisions in the realm of using or not using condoms, and young women bearing responsibility for contraception. In an ongoing collaboration between University of Glasgow, young people and service providers in the field known as Conundrum (2022) these factors are confirmed, as is the need for RSHP education to address them explicitly.

Lindberg et al. (2011) used data from a US national survey to explore whether formal sex education is associated with sexual health behaviors and outcomes. They report that receipt of formal sex education before first sex, particularly programmes that include instruction about both delaying sex *and* birth control methods, were associated with delayed onset of first sex and greater use of contraception or condoms at first sex.

In their review of evidence, Oringanje et al. (2016) report that educational interventions significantly increased reported condom use at last sex in adolescents, compared to controls who did not receive the intervention. Young people who have received school-based contraceptive promoting learning are also significantly more likely to use hormonal contraceptives than those who do not.

In their review of systematic reviews, Garzn-Orjuela et al. (2021) identify that the most positive results of educational interventions can be on the

use of condoms, especially when curriculum is supported by counselling interventions, skills training, mass media and technological/digital tools and interventions to improve communication and self-care skills.

Kirby et al. (2007) in a review of programmes found that half showed increased condom use, the rest had no effect but none of the interventions decreased condom use. Similarly, for the smaller number of programmes addressing contraceptive use almost half increased use of contraception.

Yeung et al. (2017) using a national telephone-based survey in Australia report that that sex education was strongly associated with increased odds of using contraception at first vaginal intercourse.

From a review of the international evidence on preventing and reducing teenage conceptions Cheesbrough et al. (2002) report that HIV/AIDS education programmes are very effective in increasing condom use. Poobalan et al. (2009) in a review of reviews exploring characteristics of effective sex and relationship education interventions and programmes, report that lower frequency of unprotected sex and increased condom use was achieved more often than a reduction in frequency of sexual activity itself.

Owen et al. (2010) focused on young people's targeted sexual health service models, either in school or off site, and provide evidence that the take-up of contraception by young people can be increased both by addressing their concerns about privacy and visibility, and by providing free contraception; elements of which can be addressed by RSHP provision in the Scottish context through assurances about the former, and signposting re the latter.

3. RSHP education: Conception and pregnancy

The number of pregnancies in young people is in decline. While welcome, health inequalities persist with risks of adverse maternal and child health outcomes associated with pregnancy among adolescents.

Exploring the literature around adolescent pregnancy, Santelli et al. (2007) conclude that improved contraceptive use has been the primary determinant of declining rates of pregnancy amongst young people in their teenage years; concluding that information about contraception needs to be part of school curricula.

In their review of evidence, Oringanje et al. (2016) report that a combination of educational and contraceptive-promoting interventions along with skills building significantly lowers the risk of unintended/unplanned pregnancy among adolescents. They also conclude from their review that it is difficult to assess the impact of these different elements alone, it is in their combination that an affect is seen.

In their review of data from the National Survey of Sexual Attitudes and Lifestyles (Natsal-3) Wellings et al. (2013) report that one of the factors strongly associated with unplanned pregnancy was that the main receipt of sex education was from sources *other than* school.

In a 2016 evaluation of RSHP education in secondary schools by NHS Lothian/Healthy Respect 731 survey respondents reported as follows on these issues: 76% agreed or strongly agreed that they understood contraception and 77.2% that they understood how to avoid an unplanned pregnancy.

Yeung et al. (2017), using a national telephone-based survey in Australia, report that that school-based sex education was strongly associated with lower odds of pregnancy at under age 20 years in women. Cheesbrough et al. (2002) reviewing international evidence on preventing and reducing teenage conceptions, report that raising the aspirations of girls from a very young age has a direct effect on their chances of becoming a teenage mother; those who perceive that they have more to lose by becoming a young mother are less likely to become pregnant.

4. RSHP education and sexually transmitted infections, including HIV

Undertaking a synthesis of evidence relating to sex and relationship education Pound et al. (2017) find that young people who report lessons at school as their main source of information about sex are less likely to have had unsafe sex in the past year than young people who report receiving most of their information about sex from other (non-parental) sources.

Yeung et al. (2017) using a national telephone-based survey in Australia report that that school-based sex education is strongly associated with higher levels of STI knowledge in both men and women. Learning at school was also associated with lower odds of ever having an STI in men.

In Ireland, Bourke et al (2014) investigated the relationship between school sex education and sexual health behaviours and report that adults who received sex education at school were more likely to have a history of STI testing.

Evaluations of Scottish school-based programmes have also shown impact. In 2012 a set of questions about sexual health and Blood Borne Viruses were asked from a representative sample of S3-S6 pupils (Scottish Government 2012). The majority of young people recalled being taught about blood borne viruses and how to avoid catching HIV; learners had less confidence in terms of knowledge about Hepatitis which was identified as an area requiring strengthening in the curriculum. From an evaluation by NHS Lothian/Healthy Respect (2016) most of the 731 young people surveyed remembered learning about STIs (88.6%) and about HIV/AIDS (84.1%). In an evaluation of school-based programmes by Glasgow City (2014) 93% of the 495 respondents remembered learning about safer sex, condoms and how to use them and what STIs are and where to get help. 76% of respondents also agreed that they knew how to negotiate safer sex, and 78% what HIV is and how it has affected people across the world.

In their review, drawing in international evidence, Mason-Jones et al. (2016) conclude that school-based interventions for the prevention of STIs in young people can bring about improvements in knowledge and increased self-efficacy, but do not significantly influence sexual risk-taking behaviour

or infection rates. They suggest that an additional offer of sexual and reproductive health services and access to condoms is also required.

Undertaking a systematic review and meta-analysis of school-based sex education and HIV prevention Fonner et al. (2014) found that learning at school is an effective intervention for generating HIV-related knowledge and decreasing sexual risk behaviors among participants, including delaying sexual debut, increasing condom use, and decreasing numbers of sexual partners. Interventions producing the most significant changes in behavior, reflecting findings in the work cited above, had characteristics in common: they included community-based components that extended beyond school-based inputs; training healthcare staff to offer youth-friendly services; condom distribution; and involved parents and community members in intervention development.

5. RSHP education and gender equality

In a global review of emerging evidence, lessons and practice in comprehensive sexuality education, UNESCO (2015) argues that teaching and learning about gender and rights should be consistently strengthened across curricula, so that school-based programmes should address sexual violence, gender-based violence and promote gender equality, as well as ensuring the needs and rights of all young people.

In their review of evidence of effectiveness Haberland and Rogow (2014) acknowledge that, at the time of their work, few school-based programmes had historically emphasised gender and rights. They report that emerging evidence shows that when programmes address issues of gender and power they are markedly more likely to demonstrate significant positive effects on health outcomes than those programmes that ignored topics such as early marriage, sexual coercion, intimate partner violence, homophobic bullying, girl's agency, school safety, sex trafficking and gender norms; described as a *constellation of issues*. They conclude that gender norms are a gateway factor for a host of outcomes but say that more research is needed to demonstrate the extent to which empowerment-focused comprehensive sexuality education programs act to improve outcomes.

Goldfarb et al. (2021) conducted a systematic literature review of three decades of research on school-based programmes to find evidence for the effectiveness of comprehensive sex education. They report on qualitative studies that seek to expand understanding of gender and gender norms with primary school age children. They find that accessibility to children's literature that challenges gender stereotypes, supported by discussion, can engage learners in different ways of thinking about gender-based bullying and harassment. They also report this also helped children to expand their views of gender, gender expression, and gender norms.

In their review of reviews to identify characteristics of effective sex and relationship education Poobalan et al. (2009) report that compared with young men, young women were more likely to demonstrate positive changes in sexual health knowledge, attitudes and behavioural intentions

as a result of engaging in school-based curricula. Furthermore, females appeared to be more receptive to pregnancy-prevention interventions, whilst the males tended to be more receptive to HIV/AIDS-prevention interventions. They suggest this could be due to the major social and psychological implications of pregnancy at a younger age for girls, whilst the boys might see only HIV/AIDS as a greater threat for them.

6. RSHP education and gender-based violence

Learning that gives specific attention to gender or power and promotion of gender equality can sit within the RSHP education or be part of additional or associated programmes[3]. In a comprehensive review of evaluation studies, Haberland (2015) reports on evidence that programmes with a focus on gender and power, that include personal refection, have the potential to influence an array of important sexual health outcomes. In the meta-analysis conducted, such programmes were five times more likely to be effective in reducing STI and pregnancy rates than those that did not address these topics. Haberland (2015) concludes that there is strong evidence that content about gender and power in intimate relationships should be considered a key characteristic of effective sexuality education.

Reporting on data from the *National Surveys of Sexual Attitudes and Lifestyles* (Natsal-3) Pound et al. (2017) report women who received most of their information about sex from school-based sex education are more likely to report being 'sexually competent' the first time they have sex. Sexual competence is explained as when both partners are 'equally willing', reliable contraception is used, the decision to have sex is not due to peer pressure, drunkenness or drugs, and sex occurs at the perceived 'right time'; these women are also less likely to report having experienced non-volitional sex, abortion or distress about sex.

In an evaluation of sexual health and relationship education in non-denominational schools by Glasgow City Council (2014) a pupil survey of 495 pupils found that:

- 85% of learners agreed or strongly agreed that lessons help them understand that they can say no if they don't want to have sex.
- 86% that lessons help them feel that they have a right to feel safe in a relationship.
- 88% that lessons help them think that you should never make a boyfriend or girlfriend do something they don't want to do.
- 88% that lessons help them think that you should never put pressure on someone to do something sexual.

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[3] For example, *Equally Safe at School* has been developed by Rape Crisis Scotland in partnership with the University of Glasgow https://www.equallysafeatschool.org.uk/

- 82% that lessons help them to know what consent means when it comes to sex.

Similar findings are found in the 2016 evaluation by NHS Lothian/Healthy Respect where of 731 respondents:

- 79.4% agreed or strongly agreed that lessons help them to understand that they can say no if they don't want to have sex.
- 77.3% that it helps them to feel that they have a right to feel safe in a relationship.
- 85% that RSHP learning helps them to think that you should never make a friend, boyfriend or girlfriend do something they don't want to do.
- 83.7% that it helps them to think that you should never put pressure on someone to do something sexual.
- 76.2% that it helps them to know what consent means when it comes to sex.

Goldfarb et al. (2021) also find that programmes that focus on sexual coercion, pressure, intimate partner violence and exploitation have positive outcomes including increased knowledge, changed attitudes, and improved skills in areas like communication.

7. RSHP education and the prevention of childhood sexual abuse

Childhood sexual abuse is a human rights infringement and a concern for both public health and education systems. NSPCC estimate that 1 in 20 children have been sexually abused; they have reported on growing concerns for children affected through the pandemic[4].

In their systematic literature review Goldfarb et al. (2021) looked at programmes which focused on aspects such as safe/appropriate touch, feeling safe and recognising unsafe situations and what to do. They find that such programmes do not increase anxiety, rather they are developmentally appropriate and produce positive outcomes, while providing a foundation for future learning. There is evidence that focusing on these areas supports children to improve understanding of unsafe secrets and when to tell/seek help and how to identify the person to go to. This improvement in skills, confidence and identification of a trusted adult in relation to disclosure is an important protective factor.

In a Cochrane Review exploring primary school-based education programmes for the prevention of child sexual abuse, Walsh et al. (2015) also find positive effects. Like the evidence identified above, they report that school-based sexual abuse prevention programmes did not increase or decrease children's anxiety or fear of sexual abuse. They found that programmes were effective in increasing learners' skills in protective behaviours and knowledge of sexual abuse prevention concepts (such as safety rules like ‘my body belongs to me’ or distinguishing appropriate and inappropriate touch) with knowledge retained over time. It is also reported that children who have participated in child sexual abuse prevention programme were more likely to disclose their abuse than children who had not been exposed.

One interesting result from one study described in the Walsh et al. (2015) review suggests that children with greater self-esteem exhibited better

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[4] NSPCC (2020) The Impact of the coronavirus pandemic on child welfare: sexual abuse [The impact of the coronavirus pandemic on child welfare: sexual abuse (nspcc.org.uk)]

protective behaviours following their participation in a school-based intervention. They report that this finding warrants further investigation to determine whether self-esteem training should be included as a component of child sexual abuse prevention interventions within comprehensive sexuality education.

In their research into school-based preventative education across a range of behaviours Chakravorty (2016) for the PSHE Association, finds that there is a lack of evidence around effective practice in the important area of online safety education, although they acknowledge that programme developers can draw on existing research in other areas of prevention education, given the apparent generalisability of their findings.

8. RSHP education and LGBT inclusion

In their systematic literature review Goldfarb et al (2021) report that comprehensive sex education curricula, alongside other study areas, that are inclusive of all sexual orientations, gender identities, and expressions, reduces homophobic bullying and harassment, and increases safety for lesbian, gay, bisexual and transgender students.

Proulx et al. (2018) explored the impact of inclusive school-based sex education programmes that promote positive school climate for LGBT learners. Where delivered, lesbian and gay youth had lower odds of experiencing bullying in school and bisexual youth had significantly lower odds of reporting depressive symptoms. Protective effects for all LGBT young people were found for suicidal ideation.

In an evaluation of sexual health and relationship education in non-denominational schools by Glasgow City Council (2014) a pupil survey found that 82% of learners agreed/strongly agreed that RSHP lessons lead them to conclude that people who are lesbian, gay, bisexual or transgender should be treated well by them.

For LGBT young people themselves the organisation Just Like Us (2021) reports that 33% of LGBT school students believe that seeing LGBT people and content included in school lessons makes a positive difference to daily life at school.

9. RSHP education and children and young people with learning disabilities

In a systematic review of published research evidence on RSHP programmes for children, young people and adults with intellectual/learning disabilities, Brown et al (2020) identify that there is an evolving research evidence base regarding the design and delivery of these programmes; but that there is no coherent approach to identify outcome measures or to enable an assessment of outcomes achieved.

Goldfarb et al. (2021) also acknowledge that although there has been increasing focus on this population there is limited literature that has attempted to evaluate the effectiveness of such approaches. And of course, all of this in the context of a recognition that children, young people and adults with learning/intellectual disabilities may be at greater risk for poor sexual health including sexual abuse and exploitation, pregnancy and STIs, and difficulty forging and maintaining healthy relationships. They conclude that this suggests a strong need for evaluations focused on sex education efforts with these learners.

From their review of the literature on efficacy of interventions designed to prevent and protect people with intellectual disabilities from sexual abuse, Bruder and Kroese (2005) suggest that knowledge acquisition by individuals alone does not change behaviour, and it is also necessary to teach skills (such as ability to recognise dangerous situations, respond to abusive situations by verbally refusing or escaping, reporting the event) through role play and rehearsal – echoing the findings of broader prevention education research discussed in the earlier section. They further draw the distinction between teaching skills and teaching how to generalise these skills to real-life settings, both of which must be taught.

Most recently, Paulauskaite et al. (2022) have also stressed the importance and value of producing a comprehensive list of outcomes for students with intellectual disability to be used for evaluations in research and education settings. From their systematic review of intended outcomes from programmes reported in the international literature, they report that these are often knowledge based and about 'keeping safe'. In contrast, where reported, learners with disabilities want skills and opportunities, for

example to learn how to have romantic and sexual relationships. They conclude that work on outcomes and meaningful evaluation of programmes is essential, and that it should be done alongside learners.

10. RSHP education, wellbeing and attainment/achievement

A view of RSHP education, particularly when framed as *sex education,* perhaps puts an overt focus on learning about contraception, STIs and other matters of reproductive health. RSHP education in school and other learning settings today is much more and contributes to a necessarily wider understanding of health and wellbeing. Children and young people have fundamental human rights to the complete and accurate health information, this means that school-based curricula address relationships as well as sexual health. This is reflected in how learners understand their RSHP education; for example, in an evaluation of sexual health and relationship education in non-denominational schools by Glasgow City Council (2014) a pupil survey found that 75% of learners strongly agreed or agreed that lessons help them think about what they want from a relationship.

Goldfarb et al. (2021) conclude in their literature review that there is evidence for the effectiveness of approaches that address a broad definition of sexual health and take positive, affirming, inclusive approaches to human sexuality. They report that efforts which focus on healthy relationships as a foundation for sexual health have impact when there is an emphasis on communication skills, ethics and social justice, and social emotional learning (more on this later). They also connect sexual health with broader success in terms of achievement and attainment. They conclude that if young people are able to avoid early pregnancy, STIs, sexual abuse, and interpersonal violence and harassment, while feeling safe and supported within their school environment, they are more likely to experience academic success, a foundation for future stability.

11. The effects of RSHP education on knowledge, attitudes, skills and behaviour

Many of the sources already quoted in this paper make reference to different understandings of the extent to which a school-based comprehensive sexuality education curriculum can impact across all areas of knowledge, attitudes, skills *and* behaviour.

In their review of reviews Denford et al. (2017) conclude that comprehensive, sexual-risk reduction and HIV-prevention interventions were consistently effective in changing knowledge, attitude and skills. Poobalan et al. (2009) in a review of reviews agree that educational interventions can often be seen to impact more evidently on knowledge, attitudes and intentions, rather than actual behaviour change. They find however that a successful focus on the former will result in greater likelihood of behaviour change.

In their review of evidence Kirby et al (2007) conclude that the evidence is strong that many curriculum-based sex and HIV education programmes have positive effects on relevant knowledge, awareness of risk, values and attitudes, self-efficacy, and intentions—the very factors specified by psychosocial theories as being the determinants of behaviour.

12. Other factors that inform effectiveness of RSHP education

The timing of RSHP education: Age, stage and progression as factors in effectiveness

In their review of reviews, Poobalan et al. (2009) report that educational interventions that are delivered to young people before they are sexually active can impact positively on sexual health outcomes, including delaying sexual debut; sexually active young people being less likely to change their sexual behaviour. Interventions that were found to be effective included those that were appropriately matched to the adolescents' biological, cognitive and social developmental stage, those that took account of social or media influences on sexual behaviour and those that involved parents and peers.

Goldfarb et al. (2021) also offer evidence that sexuality education is most effective when begun early and before sexual activity begins. As with all other areas of the curriculum, they report that building an early foundation and scaffolding learning with developmentally appropriate content and teaching are key to long-term development of knowledge, attitudes, and skills that support healthy sexuality.

Poobalan et al. (2009) report that as young people go through physical, social and psychological transition into adulthood over a period of time, education with a narrow focus, given in stages seems to be beneficial. This is seen as giving learners time to understand the messages rather than to over load them with multiple messages at the same time. Targeting single behaviours, and being content specific at one point of time, is identified as an important characteristic of effective intervention in reducing risky sexual behaviour.

For the PSHE Association, Chakravorty (2016) also identifies the need for education programmes to be developmental, taking into consideration the changing needs of pupils as they grow. In addition, programmes should start early enough to have an impact and be appropriately timed to the age, maturity, needs and assets of pupils. To do this, educators must conduct an assessment of the needs of pupils to understand their current understanding, culture and experiences.

Increasing effectiveness by connecting and engaging parents/carers with school based RSHP education

The RSHP national resource Home - RSHP acknowledges parents and carers as the child's first and most important educator; with information for parents and carers available across content as well as ensuring that the resource is fully open/public to support parental engagement.

There is evidence of the importance of engaging parents and carers in RSHP education, including meaningful connections to school-based delivery. In their identification of effectiveness of health literacy and personal skills programmes for primary school aged children, Jones et al. (2009) conclude that programmes that focus on communication between child and parent about sexual health can positively impact in this area.

Using a large-scale survey in the US, Secor-Turner et al. (2011) explored informal sources of information about sex and the associations with sexual risk outcomes among sexually experienced adolescents. They report that peers, siblings and parents were commonly reported source of information about sex and that having these informal, familiar sources of information about sex appears to serve as a protective factor against sexual risk outcomes, especially among younger adolescents. They conclude that engagement of peers and parents, within and allied to school-based delivery, will be protective.

In a review of international technical guidance on sexuality education UNESCO (2018) find that sexuality education is most impactful when school-based programmes are complemented with community elements, including condom distribution, providing training for health providers to deliver youth-friendly services, and involving parents.

The importance of learner engagement and active participation

Poobalan et al. (2009) emphasise the positive impact of school-based programmes that encourage participation and physical involvement of learners through approaches like hands-on skills training workshops on decision-making, negotiation, condom use, and those that involve young people emotionally, for example, providing opportunities for learners to meet people living with HIV/AIDS.

The effect of RSHP education when it builds social emotional learning and media literacy

There is an interest across Curriculum for Excellence in social emotional learning. This is the process of developing self-awareness, self-control, and interpersonal skills. People with strong social-emotional skills are better able to cope with everyday challenges and benefit academically, professionally, and socially. Goldfarb et al. (2021) identify that the incorporation of social emotional learning into a RSHP programme can be seen to impact positively on a range of social emotional outcomes including increased empathy, respect for others, improved communication, managing feelings, positive self-image including body image, and increased sense of self control and safety and establishing positive relationships.

Goldfarb et al. (2021) also point to the value of improved media literacy which can support children and young people to understand how media affects both a sense of self and perceptions of norms. McGeeney and Hanson (2017) explored young people's use of technology in their romantic relationships and love lives. They report that digital and in-person contact and communication are interwoven across young people's relationships. Utilising a UK wide online survey, they report that young people would like more on media literacy, relationships skills and confidence building in terms of school-based curricula.

The effect of RSHP education when it is explicitly rights based

The RSHP curriculum facilitated in Scotland's schools is concerned with children and young people's human rights and is delivered in the context of incorporation of the UNCRC into Scots law. Using a cluster randomised trial Constantine et al. (2007) explored the short term effects of a rights-based sexuality education curriculum in the US and found that compared with students who received the control curriculum, not articulated as rights-based, students receiving the rights-based curriculum demonstrated significantly greater knowledge about sexual health and sexual health services, more positive attitudes about sexual relationship rights, greater communication about sex and relationships with parents, and greater self-efficacy to manage risky situations at immediate post-test. There were no significant differences between the two groups for two

outcomes, communication with sexual partners and intentions to use condoms.

The effect of interactive digital interventions

Bailey et al (2015) undertook a scoping review exploring sexual health promotion for young people delivered via digital media. They report that digital approaches are effective for knowledge acquisition and sexual behaviour and could usefully contribute to sexual health education in schools, in clinic settings and online; however, there are obstacles to overcome, such as access to information technology and ensuring the quality and safety of interventions. They conclude that more evidence is needed on the best designs for interventions and the best models of delivery to improve sexual behaviour, biological outcomes and sexual well-being in a cost-effective way.

Kantor et al. (2020) acknowledge that the digital space is increasingly where young people obtain sex education. They conclude that digital interventions have the potential for both efficacy and can be delivered at scale, and may be particularly important now, given school disruptions due to COVID-19.

CONCLUSION

Using evidence from three *National Surveys of Sexual Attitudes and Lifestyles*, Tanton et al (2015) conclude that school lessons have become the main source of information about sexual matters for increasing proportions of young people.
Learners themselves acknowledge school as a main setting for RSHP learning. In a NHS Lothian/Healthy Respect (2016) evaluation of RSHP education 67% of the 731 respondents agreed/strongly agreed with the statement: *School is the place where I learn most about sexual health and relationship topics*. Earlier evaluation work across non-denominational schools by Glasgow City Council (2014) saw 63% of 495 respondents agree/strongly agree with this statement.

However strong the evidence of impact of RSHP education across a range of themes and topics, it is important to remember that school-based curricula is only part of a complex jigsaw of support and educational interventions that children and young people need to ensure they have healthy, happy and safe personal relationships and the best of outcomes for their sexual and reproductive health as adults.

Kantor et al. (2020) make the point that it is vital to connect learning at school with parents and carers, community based young people's services, health care providers, faith communities, and the media who all contribute to young people's education; they frame this as harnessing and using the power of these multiple people and institutions to provide young people with needed information, skills, and resources. Kirby et al. (2007) also recognise that school-based curricula alone cannot solve the challenges of STIs, HIV or unintended pregnancy; but programmes can change sexual and protective behaviours in desired directions, and they can be an important component in larger more comprehensive initiatives.

Haberland and Rogow (2014) remind us that the 1994 International Conference on Population and Development's (ICPD) Programme of Action, often referred to as the Cairo agenda, calls on governments to provide sexuality education to promote well-being and specifies key features of such education. It clarifies that such education should take place both in schools and at the community level, be age appropriate, begin as early as possible, and foster mature decision making. This reinforces and further specifies the shared commitment we need to make

to provide formal and informal comprehensive sexuality education, what we call RSHP education, as part of promoting, protecting and fulfilling the rights of all children and young people.

ABOUT DEVELOPING THIS EVIDENCE BRIEFING PAPER

The work undertaken has identified, selected, assessed and summarised key findings of impact from a range of sources:

- Published academic evidence (available in systematic evidence reviews over the last 20 years)
- Primary research conducted in Scotland (in the last 10 years)
- Grey literature with a focus primarily on Scottish evidence but drawing on key UK or European level evidence published in English.

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https://www.sexeducationforum.org.uk/

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