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Relationships and Sex Education: The Evidence

Working together for quality
relationships and sex education

Contents

This briefing aims to provide an accessible and accurate summary of the latest research evidence relating to relationships and sex education (RSE), particularly the contribution of RSE to behaviour change. This document is an update to **our previous evidence briefing (2015)**.

What is relationships and sex education?

Relationships and sex education is learning about the emotional, social and physical aspects of human development, relationships, sexuality, wellbeing and sexual health.

In England, as of September 2020, all secondary schools are required to teach Relationships, Sex and Health Education, and all primary schools must teach Relationships and Health Education. It is recommended that all primary schools also have a programme of Sex Education to ensure a smooth transition to secondary education, for example covering how a baby is conceived and born (DfE, 2019). **Click here** to access the full statutory guidance.

Terminology

In this document we use 'relationships and sex education' to describe this subject area in line with policy in England. Internationally, policy and literature has shifted towards the term 'sexuality education', which aims to offer a more holistic framework, and a deliberate move away from the traditional biological/reproductive focus of 'sex education' (New Zealand Government, 2020).

In its International Technical Guidance (2018), UNESCO uses the term 'comprehensive sexuality education', which it defines as: *'a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.'*

This briefing also refers to 'sexual health'. Here we draw on the World Health Organisation definition, which defines sexual health as 'a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled'.

What does relationships and sex education aim to achieve?

Relationships and sex education, at both Primary and Secondary level, aims to:

- Increase children and young people's ability to make informed decisions about their physical health, and contribute to positive sexual health outcomes including consensual and pleasurable relationships;
- Improve children and young people's emotional well-being and mental health;
- Support children and young people to develop critical thinking skills, including around gender equity, power dynamics in relationships and digital literacies;
- Inform children and young people of their rights and responsibilities in society, helping them to contribute positively to the world around them;
- Reduce harmful behaviour, including sexual violence and relationship abuse, stigma and discrimination, both online and offline;
- Safeguard children and young people by supporting them to report harmful behaviour, both online and offline;
- Support children and young people to develop positive relationships with themselves and others based on respect and equality.

What do children and young people say?

Research suggests that young people are dissatisfied with the quality, inclusivity and thoroughness of the RSE provided to them at school.

The Sex Education Forum recently conducted a survey of 1002 young people aged 16-17 in England (2022). This found that more than one in five (22%) young people rated the quality of RSE as 'bad' or 'very bad', an increase of 4 percentage points since 2019. The poll also revealed that 'basic, mandatory aspects of the curriculum, such as healthy relationships, and how to access sexual health services are frequently missed', with close to 3 in 10 (28%) young people saying that they had not learnt about 'how to tell if a relationship is healthy'.

Independent research found that young people express a desire to be taught about subjects such as healthy relationships, abuse, including online harms, and consent from a younger age (Ringrose et al., 2021; Hamilton-Giachritsis, 2017). This was echoed in the Sex Education Forum's 2021 poll in which young people said that they would also like to have more open conversations with parents and carers from a younger age.

Meanwhile, Brook and the University of Sussex's 2021 report found that RSE 'is seen [by young people] to be out of date, both in terms of old-fashioned binary sexual politics (straight and gay) and a failure to engage constructively with contemporary digital cultures'.

Similarly, 39% of respondents to Sex Education Forum's latest survey said that they didn't learn anything about information relevant to trans and non-binary people (2022).

Does relationships and sex education work?

Studies to date have largely focussed on the physical health outcomes of RSE, for example reduction in rates of unintended pregnancy and sexually transmitted infections, including HIV. However, in line with more holistic understandings of both RSE and of the notion of 'health', growing attention is being paid to RSE's impact on young people's behaviour and attitudes, including respect for one another, and their emotional wellbeing.

1. It reduces harm - including sexual violence

Since our previous evidence briefing a light has been shone on the scale of sexual violence in UK schools, initially through the thousands of testimonies from young people shared on the 'Everyone's Invited' website. This was followed by Ofsted's rapid review into sexual harassment and sexual violence in UK schools, which found that sexual harassment occurs so frequently it has become 'commonplace' (Ofsted, 2021).

Research has demonstrated that RSE is a potential vehicle through which to address the root causes and cultures of sexual and gender based violence, if it is framed through an equity and rights lens. This approach should address the normative contexts of relationships and sexual behaviours and development (Yilmaz and Willis, 2020). This type of RSE balances protective and participatory rights, acknowledges young people's agency and autonomy, and can, in turn, support positive peer relations while reducing harm (Berglas et al., 2014; Kantor et al., 2021; Miedema et al., 2020).

Goldfarb and Lieberman (2021) conducted a systematic literature review in which they examined the past three decades of research on school-based RSE. This also provided strong evidence that RSE can reduce both sexual and domestic violence. One long-term sexual violence prevention intervention review showed reduced perpetration of sexual violence immediately post-intervention, as well as reduced victimisation of physical violence at the 4-year follow up. Compared with controls, intervention schools reported 25% less psychological abuse perpetration, 60% less sexual violence perpetration, and 60% less physical violence perpetration with a current dating partner.

The review also found that RSE programmes can effectively reduce rape culture by addressing the harmful attitudes and beliefs that serve to uphold this culture. Programmes they reviewed resulted in a reduction in rape myths, victim-blaming and reduced social acceptance of sexual coercion and harassment. With regards to primary-aged children, Goldfarb and Lieberman found strong evidence for the effectiveness of child sexual abuse prevention efforts, including teaching young children about bodily autonomy and communication.

2. Young people are more likely to seek help or speak out

A Cochrane review (2015) found that 'children who are taught about preventing sexual abuse at school are more likely to tell an adult it they had, or were actually experiencing sexual abuse'. The Cochrane researchers reviewed data from 24 trials in which a total of 5,802 children took part in school-based prevention programmes in the US, Canada, China, Germany, Spain, Taiwan, and Turkey. In children who did not receive the intervention, around 4 in 1,000 children disclosed some form of sexual abuse. This contrasts with 14 in 1,000 children in the intervention groups, who disclosed some form of sexual abuse.

Similarly, Goldfarb and Lieberman's 2021 review found that school based programmes increased reporting of domestic violence, and cites a systematic review of childhood sex abuse curriucula in the U.S. and Canada which 'concluded that one of the most common effects was increased knowledge of a resource person to whom children would report abuse'. Part of the improved disclosure skills and behaviours included increased parent-child communication. This is echoed by UNESCO, which cites short-term positive effects of RSE including increased communication with parents and carers about sex and relationships (2016).

3. Young people more likely to practice safe sex and have improved health outcomes

RSE delivered in school classrooms can contribute to improved sexual health, including preventing unintended pregnancies and STIs (DiCenso, 2002; Kirby, 2007; Mason-Jones 2016; Downing, 2006; Oringanje et al., 2009). Kirby (2007) found that young people who have taken part in good quality[1] RSE programmes are also more likely to use condoms and contraception when they subsequently first have sex. A cluster randomised trial tested a school-based intervention entitled 'If I Were Jack', and found increased contraception use among those already sexually active (Lohan et al., 2022). Similarly, analysis of Natsal-3 data evidenced that young people who reported school as their main source of RSE were less likely to have a sexually transmitted infection, a pregnancy before 18 or an unplanned pregancy later in life (Macdowall et al, 2015). The second Longitudinal Study of Young People in England (LSYPE2) also found that young people who did not receive any RSE in schools were more likely to go on take more 'sexual risks', including intercourse before the legal age of consent and unprotected sex (DfE, 2021a).

Since our previous briefing, UNESCO conducted a 2016 evidence review on comprehensive sexuality education, based on results from 22 rigorous systematic reviews and 77 randomised controlled trials in a broad range of countries and contexts. This review reaffirms that RSE programmes can contribute to reduced risk taking, increased use of condoms and increased use of contraception; and that RSE, in or out of schools, does not increase sexual activity, sexual risk-taking behaviours or STI/HIV rates.

[1] See 'good quality' defined on page 7.

Does talking to young people about sex encourage them to do it?

There is no evidence that RSE hastens the first experience of sex. These findings are confirmed by three separate evidence reviews: Kirby 2007, UNESCO 2016 and NICE 2010. Kirby (2007) examined 48 US-based comprehensive RSE programmes and found that two-thirds of these programmes had positive effects on behaviour. 40% of the programmes had a significant impact in three aspects of behaviour: delaying the initiation of sexual intercourse; reducing the number of sexual partners; and increasing condom or contraceptive use. None of the studies hastened the first experience of sex ('sex' defined in this review as intercourse). Some RSE programmes have been found to reduce the frequency of sex, and none of the programmes reviewed by Kirby (2007) resulted in young people having sex more frequently than others, nor did teaching young people about contraception contradict messages about delaying the first experience of sex (Kirby, 2008).

Equally, there is robust evidence that an 'abstinence only' approach is ineffective in terms of both behaviour and health outcomes (Guttmacher Institute, 2007; Haberland and Rogow, 2015; UNESCO, 2018).

4. More likely that 'first sex' is consensual

The third British National Surveys of Sexual Attitudes and Lifestyles (Natsal-3) found that men and women who reported school lessons as their main source of sex education (vs. friends/other sources) were more likely to be 'sexually competent' at first sex. 'Sexual competence' has been defined through Natsal in terms of the following at first sex: use of contraception; autonomy of decision to have sex; consensuality (equal willingness of both partners); and individuals judging it to have been the 'right time'. (See also Palmer et al. 2017; Macdowall et al, 2015).

Partnerships with a big age difference (age-discrepancy) are also associated with intimate partner violence (Barter, 2009). In a large study carried out in the United States, female respondents who had received 'comprehensive sexuality education' were less likely to have a partner with a big age difference (3 years or more younger/older) at first sex and more likely to describe first sex as wanted, compared to those receiving abstinence-only or no RSE. Male respondents were less likely to have had an age-discrepant partner at first sex if they had had either type of RSE. In this United States study Lindberg also found that young people who had received comprehensive RSE were less likely to describe first sex as unwanted (Lindberg, 2012).

5. It can improve digital literacies

Studies examining the impact of RSE have typically focussed on sexual health attitudes and outcomes, age of first sex and number of sexual partners. Media literacy skills as an outcome of RSE has been little explored but becomes increasingly important given digital technologies are part and parcel of all aspects of young people's lives today. This includes having access to technologies that can take and share images, and access to online pornography.

Goldfarb and Lieberman reviewed two RSE programmes in the US for 13-14 year olds, which found increased media literacy improved understanding of how the media affects both sense of self and perceptions of teen norms (2021).

McGeeney and Hanson's Digital Romance Report for Brook (2017) found that young people wanted their school to provide a non-judgemental space for them to learn about media literacy, in order to support them to develop positive relationships, including through digital technologies, without harm. Ringrose and colleagues found that participatory workshops using arts-based practices which explored young people's experiences on social media increased understandings of digital consent, including image-based sexual harassment and abuse (Ringrose et al., 2019; Ringrose et al., 2021).

6. RSE can boost gender-equitable attitudes and improve mental health

Goldfarb and Lieberman examine a number of studies which report 'outcomes related to increased knowledge, awareness and appreciation of gender equity and sexual rights, and awareness of discrimination and oppression based on gender and sexual orientation' (2021). This included a 2015 survey of 1,232 secondary school students from 154 schools in California, which found that LGBTQIA+ inclusive curricula were associated with higher reports of safety for individuals and lower levels of bullying in the school. They also cite other methodologically strong studies which have linked LGBTQIA+ inclusive education to lower reports of adverse mental health (suicidal thoughts and suicide plans) among all young people, irrespective of gender or sexuality.

They also examined school-based bystander intervention programmes which demonstrated increases in reported positive bystander behaviours. A strong randomised study of coach-led interventions in 16 US secondary schools increased intentions to intervene, gender-equitable attitudes and improved bystander actions in male attitudes both at post-intervention and 1 year follow-up. Supporting individuals to become active bystanders is a key component to addressing social injustices such as sexual violence, transphobia and racism. It can reduce these harmful behaviours (e.g. by making them less socially acceptable/normalised), can reduce feelings of isolation experienced by those discriminated against and boost feelings of safety and empowerment.

UNESCO (2018) cites potential effects of RSE in contributing to changes beyond health outcomes, including 'increasing gender equitable norms' and 'building stronger and healthier relationships'.

What is 'good quality' relationships and sex education?

Numerous studies and reviews (Kirby, 2007 and 2008; Trivedi, 2007; Pound et al., 2017; UNESCO 2018) have identified characteristics of effective RSE programmes. The list below is not exhaustive, but explains several key themes.

Comprehensive, accurate and up-to-date

Effective RSE moves beyond the narrow, traditional areas of biology and reproduction, taking a broader view of health and sexuality by including topics such as consent, identity and online harms such as digital sexual harassment (Pound et al., 2017; UNESCO, 2018). This should include developing children and young people's life skills (communication skills, ethical decision making skills, listening skills) as well as growing their knowledge on topics such as consent, their own and others' rights and identities (Pound et al., 2017; UNESCO, 2018). It should also include medically-accurate and complete information about conception, contraception, pregnancy choices, reproductive health and STIs (UNESCO, 2018).

In order to cover the breadth of topics recommended by UNESCO (2018), the DfE (2019) and the Sex Education Forum (2018), schools are necessarily required to ensure thorough planning, and the allocation of dedicated timetable space for RSE.

Taking a rights-based and gender-and-power perspective

UNESCO (2018) endorses RSE that addresses rights, values, and equality, and how gender norms and inequalities impact sexual health and wellbeing, including harmful sexual behaviours. Pound et al. (2017) also stress the importance of challenging gender inequalities as a feature of best-practice RSE.

Both UNESCO (2018) and Haberland and Rogow (2015) found programmes which approach RSE with a gender and power lens to be particularly effective in terms of reproductive and sexual health outcomes - more so than programmes which took a gender-blind approach.

What's 'down there'?

At primary level, correct names for body parts including the genitalia should be taught, since children will often have inaccurate, euphemistic terms for the genitals. This knowledge is important for several reasons:

1. Basic factual and scientific accuracy;
2. Safeguarding: it provides children with the language to report abuse (Ofsted 2013);
3. Scaffolded learning: words for anatomy are a foundation upon which children can go onto learn about more complex bodily functions later in school (e.g. puberty; reproduction; STI prevention, etc.);
4. The removal of unnecessary shame and stigma which can affect emotional wellbeing as well as prevent individuals from seeking support (e.g. feeling reluctant to visit GP about a menstrual health or genital-related problem);
5. Empowerment: understanding one's body can help grow feelings of bodily autonomy, including discussing boundaries and personal pleasure with a partner if/when sexually active.

Inclusive of all learners

Effective RSE is accessible to all children and young people. This should include actual access to provision, but also a consideration of inclusion in relation to curriculum content and pedagogy.

LGBTQIA+ young people in particular report their school RSE teaching being either heteronormative (non-inclusive of non-heterosexual identities and sex) or being overtly homophobic, and report consequent feelings of shame, of one's sexuality not being 'legitimate' and lack of preparedness for first sex (Gillespie et al., 2021). Meanwhile, young people who are neurodiverse or have a physical disability are also routinely excluded from RSE, both in terms of access and classroom practice. For example, a survey by charity Deafax found that 35% of d/Deaf people did not receive any sex education at school, and 65% said that the information was inaccessible (2012). LSYPE2 findings support this, with young people who identified as lesbian, gay or bisexual, and those with a long-term disability, being significantly more likely to say that their school RSE was 'not at all useful' (DfE, 2021a). Lack of access to relevant RSE - which is evidenced to boost health, happiness and safety - further compounds the existing vulnerabilities that marginalised young people can face.

Research has documented how young people of colour face racist assumptions in RSE, for example educators implying that Latina girls have a tendency to be sexually promiscious (Garcia, 2009), owing to 'a long racist history of seeing girls of colour, particularly African American girls, but also Latina girls, as [...] hypersexual' (Lamb et al., 2017). Extensive research evidences the adultification[2], particularly of Black youth, which results in detrimental failures to adequately safeguard young people of colour (Davis and Marsh, 2020; Bernard and Harris, 2019) and a greater likelihood of punitive measures against them. Black Caribbean students are three times more likely to be excluded than their white counterparts (Gillborn et al., 2018), meaning they are also more likely to miss RSE. A 2020 report by Runnymede summarises 'racism is deeply embedded in [UK] schooling' and that 'school curricula too often fail to reflect the diversity of contemporary society': the RSE classroom will not be exempt from these forms of discrimination and biases.

With regards to religion, a 2021 report by FACES (Faiths Against Child Sexual Exploitation) examined taking pupils' religious backgrounds into account in RSE. The report found that students either felt like aspects of their identity were erased, or homogenised, i.e. assumptions were made about their lives, choices and experiences. This again points to the importance of meaningfully including young people in curriculum design (see 'timely and responsive' below) rather than planning lessons based on adults' judgements about all or groups of young people, which can be prejudiced and/or inaccurate.

It is important to note that many students will experience multiple forms of discrimination described above at once - the concept of 'intersectionality' (Crenshaw, 1989).

The inequalities described above do of course require system change beyond improved RSE. However, the evidence does reinforce the importance of training for RSE educators, for example in anti-racism, unconscious bias, understanding gender and sexuality, personalised learning and trauma-informed practice, to ensure teaching is as inclusive as possible. When RSE teaching takes active care to account for the diversity of young people in the room, the subject has the potential to increase their sense of inclusion and empowerment, help them feel seen by their teacher (or healthcare professional/ parent/carer etc.) and can improve others' awareness and appreciation of diversity (Goldfarb and Lieberman, 2021).

[2]The NSPCC defines adultification as 'a form of bias where children from Black, Asian and minoritised ethnic communities are perceived as being more 'streetwise', more 'grown up', less innocent and less vulnerable than other children. This particularly affects Black children, who might be viewed primarily as a threat rather than as a child who needs support'. (**Web**, 2022).

Trained educators

RSE is more effective when taught by willing and competent teachers: delivery is just as important as content (Kirby, 2007; Pound and Campbell, 2017; Jenkinson et al., 2021). Young people have said RSE is best when teachers are confident, unembarrassed and able to teach correct biological facts and also explore relationships issues. Professionals identify best-practice RSE to be interactive and engaging, be taught in a safe environment, be delivered through a spiral curriculum and take a 'sex-positive'[3], culturally-sensitive and life-skills approach (Pound et al. 2017). This includes avoiding scare-tactics or giving extreme examples to induce fear or shock: efforts to scare young people into changing their behaviour have been found to be ineffectual, and even counterproductive (Hanson, 2022; McWhirter, 2008). Thorough and ongoing training is vital to understand and develop effective pedagogical practices, and teachers must be confident that they will receive managerial support.

A recent joint survey by the NSPCC and teaching union NASUWT found that nearly half of secondary school teachers (46%) do not feel confident delivering RSE (2022). Similarly, in a Sex Education Forum survey (2018a) a mere 6% of teachers had learnt about RSE as part of their initial teacher training, and less than half of teachers said their training to deliver RSE is adequate. Independent research has shown that a lack of training is a key barrier to teacher comfort, alongside a lack of statutory teaching resources and fear of external criticism, especially by parents (Lodge et al., 2022).

Timely and responsive

Evidence shows that RSE works best if it starts before a young person is sexually active and if it responds to the needs of young people as they mature (UNESCO, 2018; Kirby, 2007). A synthesis of evidence on best practice in RSE also found that programmes 'identified as good by professionals in the interview study' were those that delivered the subject from primary school onwards (Pound et. al., 2017), starting with topics such as personal safety, bodily boundaries and friendships. Both primary and secondary school pupils, particularly girls, have said they need RSE to start earlier (Ofsted, 2013). In a UK survey of 1000 girls aged 14-21, 25% said they did not know what to do when they started their period, suggesting that puberty education is being provided too late (Plan International UK, 2018).

There is often a disconnect between adults' perception of children and young people's needs around RSE, and what young people say they need and want from RSE; meaningful student involvement is an effective strategy to bridge this divide. This includes a need for adults to challenge their own and each other's assumptions about what matters to young people, and to find creative ways to allow young people to share their views, and create systems to make this an ongoing process, so that RSE is responsive (Renold, 2020; Quinlivan, 2018). Kirby (2007) also lists addressing 'psychosocial factors' as one of the key characteristics of effective RSE, i.e. exploring/transforming teen knowledge, beliefs, attitudes and perceived norms around sex, all of which can influence sexual behaviour.

For examples of incremental and responsive curriculum resources, see UNESCO's International Technical Guidance (2018), the Sex Education Forum's curriculum design tool and AGENDA's creative audit tool.

[3]Defined by Pound et al. as 'an approach that is open, frank and positive about sex, that challenges negative societal attitudes to sex and that embraces sexual diversity at the same time as emphasising the importance of consent and comprehensive SRE' (2017).

Context matters

The school context within which RSE takes place is essential to its effectiveness, and a joined-up approach between schools, parent, carers and local health services is vital to ensuring children and young people get the information and support they need.

Bragg et al. (2022) examined two RSE pilot studies in two English secondary schools and highlighted the importance of processes and culture beyond the classroom, including meaningful engagement with parents and carers, with students themselves in curricula development and updating policies and procedures particularly when these are in contradiction to RSE teaching. The authors explain that 'the significance of these wider aspects in enabling or constraining positive change should not be underestimated'. Kirby (2007) also points to evidence that parental engagement in RSE programmes can boost the positive outcomes for their children, including decreased sexual risk taking.

Analysis of the US-based 'Safer Choices' programme has also demonstrated the effectiveness of a whole-school approach to RSE. The intervention involves a school health promotion council, a classroom-based sexual health curriculum, a student-run social marketing campaign and information for parents, and has been found to result in multiple sexual health benefits, including increased condom use and effective contraception use compared to controls (Coyle, 1999; Coyle 2001).

A whole-school approach is also vital to addressing sexual violence: whilst RSE can be an effective form of sexual violence prevention (see page 3), it cannot do the work alone. Rather, leadership strategies, policies and procedures must be geared towards addressing and dismantling rape culture, including victim-blaming and everyday sexism (Ringrose et al., 2021; DfE, 2021).

Children and young people themselves are also clear that they want to talk to their parents and carers about sex and relationships, but many parents and carers feel they lack the skills, confidence and knowledge to have these conversations (Stone et al., 2013 and 2017). The result is that many avoid such subjects, with Sex Education Forum data revealing that for many young people (23%), there had been no RSE from parents and carers, but for those that did receive some it was more often one big talk or a few separate talks (2022). Natsal-3 also highlighted that parents and carers, especially fathers, are falling short of what young people would like when it comes to information about relationships and sex (see Sex Education Forum, 2015). Greater support and resources are therefore needed in order to give parents and carers the confidence to have these important conversations (Robinson, 2017).

“Where do babies come from?”

Children are naturally curious - questions such as the one above can come from children as young as 2 or 3 - but many parents can find small children’s questions about life cycles, sex and sexuality challenging to answer, or express uncertainty around whether to do so. Whilst parents may feel they are protecting a child’s ‘innocence’ by restricting such conversations, research suggests that the opposite is true: early and open communication can impact positively on a child’s health and safety (Stone et al., 2012 and 2017).

Santelli (2007) found that alongside good-quality RSE, young people need to be able to access sexual health and contraceptive services in places that are convenient to them. Pound et al. (2017) also found school-based or school-linked sexual health services to be effective in reducing sexual activity, number of sexual partners and teenage pregnancies, and that young people who attended a school-linked clinic were enthusiastic about this and appreciated the service provider’s expertise.

Research indicates that young people were disproportionately impacted by the COVID-19 pandemic and the challenges to accessing sexual and reproductive healthcare during this time, owing to factors such as walk-in closures and hesitancy from young people to use digital services (Dema et al., 2022; Thomson-Glover et al., 2022). This affirms the importance of accessible, face-to-face sexual health services for young people.

Summary

Independent, peer-reviewed and published research from a wide range of academic and credible sources nationally and internationally demonstrate that RSE contributes to improved physical and mental health for children and young people. Specifically, when they have received RSE, young people are:

- More likely to seek help or speak out;
- More likely to practice safe sex and have improved health outcomes;
- More likely to have consented to first sex, and for first sex to happen at an older age;
- More likely to have an understanding of digital safety in regard to relationships and sex;
- More knowledgeable and aware of discrimination, gender equity and sexual rights;
- Less likely to be a victim or perpetrator of sexual violence.

The body of research summarised in this briefing provides clear direction on pedagogies for effective and high quality RSE, including:

- Educators need to be trained;
- Information must be medically and factually accurate and up-to-date;
- Participatory approaches are more effective;
- Psycho-social factors need to be addressed;
- Provision needs to be timely and responsive to children and young people’s needs;
- Avoidance of scare tactics;
- Accessibility for all children and young people is achieved through greater awareness of the vulnerabilities of marginalised children and young people;
- Involving home and school is more effective;
- Access to advice and sexual health services;

The research findings reported here align closely with the views of young people that have been documented in conversations, consultations and surveys about their experiences and needs.

We want more RSE at school

"More time to develop an understanding of it all, instead of rushing the whole subject to get it over and done with."

More time

More talking

More honesty

More normal

More diverse

More in-depth

More open

More non-judgemental

More about relationships

...We want more RSE!

Source: Sex Education Forum, 2022

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About the Sex Education Forum

The Sex Education Forum is the voice of Relationships and Sex Education (RSE) in England. As a national charity, we promote and protect the physical and mental health of children and young people by improving their access to RSE. To find out more and join our RSE community visit:

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