Comprehensive Relationships and Sexuality Education and Reproductive Health for Children and Young People at School

Policy Position Statement

Key messages:

The PHAA is committed to work with key stakeholders to ensure that age and developmentally appropriate and pedagogically inclusive comprehensive relationships and sexuality education (CRSE) addressing safe sex, healthy relationships, and informed decision-making, including about consent, that aligns with the Australian Curriculum is implemented in schools.

Key policy positions:

1. Acknowledge and address the needs of all young people, including those with diverse genders, sexualities and variations of sex characteristics using a human-rights-based, intersectional lens.
2. Work with stakeholders to develop, implement, and continuously evaluate gender, sexuality, and reproductive health school curricula that align with the Australian Curriculum and are student-centred, inclusive, culturally aware, safe, competent and trauma-informed.
3. Schools must address homophobia, biphobia, transphobia, discrimination against young people with variations of sex characteristics, gendered patterns of violence, sexual violence, stigma, gender, negative stereotypes, and sexuality-based discrimination and promote the rights of young people to reduce marginalisation.
4. Government and key stakeholders work together to develop best practices and curricula and to mandate that CRSE is taught in all Australian schools to ensure reproductive health needs and rights of young people are met in positive and inclusive ways.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Diversity, Equity and Inclusion Special Interest Group and Child and Youth Health Special Interest Group

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20 Napier Close Deakin ACT Australia 2600 – PO Box 319 Curtin ACT Australia 2605
T (02) 6285 2373 **E** phaa@phaa.net.au **W** www.phaa.net.au

Comprehensive Relationships and Sexuality Education and Reproductive Health for Children and Young People at School

Policy position statement

PHAA affirms the following principles:

1. In line with the World Health Organization (WHO), PHAA recognises that sexual health is a state of physical, emotional, mental, and social wellbeing related to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships and 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. Sexuality is a key part of each person's identity and includes "sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction [within] the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors". There is growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of certain human rights enshrined in existing laws.[1]

2. Educating children and young people about their rights to access health care, Medicare, health service provision, navigating the healthcare system, access to contraception and vaccinations should be supported and promoted.

   Definition: *For the purpose of this policy, the term "children and young people" includes those aged 4-18 years as well as young people aged 19-25 who are attending secondary school.*

3. Young people's right to health includes freedom and control over their bodies, including their sexual and reproductive health choices.[2] These entitlements include access to supportive adults, systems, resources, services, and conditions that provide equality of opportunity for every young person to enjoy the highest attainable standard of health.

4. Cultural and religious beliefs often play a key role in discourses about gender, sexuality, and variations of sex characteristics for young people. The PHAA advocates for the rights of young people to have access to culturally safe, trauma-informed, evidence-based information, education, and health services.[3]

5. Intersectionality promotes an understanding of the interconnected nature of social categorisations such as (but not limited to) age, Indigenous identities, ethnicity, culture, migration status, refugee and asylum seeker backgrounds, socioeconomic status, geographic location, sex, sex characteristics, gender, sexuality, disability, and religion as they pertain to disadvantage and discrimination.[4]

6. Children and young people are frequently excluded from access to gender, sexuality, sex and relationships education and support. This is due to their age and societal perception of this information as being irrelevant to their age group,[5] and in some cases, adult discomfort in addressing

these issues with young people. This lack of information intersects with and compounds other social determinants of health that can further marginalise children and young people.[6]

7. Education, both formal and informal, plays a key role in attaining sexual health. Schools have a crucial role in introducing children and young people to gender, sexuality, reproductive health and age-appropriate affirmative information about intersex variations.[7] [8] All young people should have an understanding of blood borne virus transmission, and young men who have sex with other men should have an understanding about the prevention of HIV through HIV Preexposure Prophylaxis medication.

8. Young people want consistent, engaging and affirming comprehensive sexuality education (CSE) covering a range of age- and developmentally appropriate content provided by well-trained teachers who are comfortable with the topic. Such education may allow students to practice safe sex, be comfortable with their sexuality, recognise healthy relationships and make informed decisions.[9]

9. To ensure safety and wellbeing, schools need to address the issues of homophobia, biphobia, transphobia, sexual violence, stigma, gender, and sexuality-based discrimination and promote the rights of young people to reduce marginalisation.[10] [11] [12] [13] [14]

10. Comprehensive sexuality education is "a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality". [15] CSE equips young people with knowledge, skills, attitudes, and values to make considered and adaptive choices on their relationships, behaviours, and sexual health and wellbeing.

11. Pedagogically inclusive and affirming curricula addressing the importance of consent and bodily autonomy in a development- and age-appropriate manner is critical. Health literacy, including information about rights to make health decisions, is important to strengthen young people's knowledge, motivation, and competency to make well-informed health decisions.[16] [17] [18]

12. The development of an equitable and socially just CSE program should involve young people, parents/family and other community stakeholders, in addition to experts in human sexuality. It is also essential that the development of such programs be grounded within contemporary evidence-based standards or guidelines. Importantly, research emphasises that the delivery of CSE is just as important as the content.[19]

13. Teachers need to be trained on CSE at the tertiary level and supported through accredited, up-to-date continuous professional development. Such training must address self-reflective practice, including allowing teachers to voice and mitigate their own biases. Where current school staff have not received such professional development, a whole school approach is recommended to ensure the same values and language are used by all staff across the site.

14. There is evidence to suggest that school-based interventions which promote education about informed and affirmative consent to sexual activity can effectively prevent or decrease intimate partner violence, victimisation among adolescents, and the emotional harm that such violence can cause.

PHAA notes the following evidence:

15. Quality CSE has been shown to reduce rates of sexually transmissible infections (STIs), unintended pregnancy, identify and report sexual assault or rape, and improve young people's capacities to seek

ongoing and enthusiastic affirmative consent from their sexual partners, and delay sexual activity until they feel ready to engage with consideration of the age of consent in their jurisdiction.[20]

16. CSE incorporates a focus on the following: 1) relationships and emotions, 2) values, rights, culture and sexuality, 3) understanding gender, 4) the human body and development, including affirmative information about atypical development and bodily diversity, 5) inclusive sexuality and sexual behaviour, 6) sexual and reproductive health 7) violence, sexual coercion and exploitation, and staying safe, 8) online safety, sexting and cyberbullying and 9) development of health literacy skills, including where and how to access services that provide acceptable and youth-friendly sexual and reproductive health care.[21] [22]

17. Seventy-two per cent of young people agree that schools should discuss sexuality, with 86% believing that secondary school students have the right to learn about Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual (LGBTQIA+) people and 81% believing that sexuality education should be relevant to LGBTQIA people.[23] Most secondary school students reported that they received relationships and sexuality education (RSE; 83.6%) at school. Most RSE was delivered by their regular teacher (82.1%) as part of their Health and Physical Education (HPE) subject (70.6%) in Years 7-8 (75.9%) and/or Years 9-10 (80.8%). One in three (37.8%) students found their RSE very or extremely relevant.[24] Young people want more inclusive and realistic information about sexual and gender diversity, innate variations of sex characteristics, violence in relationships, consent and coercion, pornography, intimacy, sexual pleasure, and love, among other topics.[25] [26]

    Definition: *the collective term "LGBTQIA+" is not all-encompassing and does not capture the complexities of everyone's experiences, and will therefore resonate with people differently. This term is used in this policy in the absence of a national consensus, after consultation with LGBTIQ+ Health Australia, Intersex Human Rights Australia, and other key stakeholders across several states.*

18. Young people express the need for more practical and interpersonal skills such as the navigation of healthy relationships, how and where to access help and youth health services. Those from minority groups, e.g., migrant or refugee backgrounds,[27] people of diverse genders, sexualities, and variations of sex characteristics,[28] [29] young people living with disability often report being unable to access this information. [30] [31] [32]

19. A key priority area is for young people to have a sound understanding of HIV, STIs and blood-borne viruses, including knowledge of transmission, symptoms, and risk mitigation. Young people also need health services that are youth-friendly, close to public transport, open before and after school and weekend hours, with staff who are trained to work with young people, inclusive intake forms (gender, sexuality, Indigeneity), and specialising in young people's health/sexual health.

20. Evidence of poorer physical and mental health and wellbeing outcomes for diverse young people include:

    i. Many young people lack knowledge about the availability and accessibility of various youth-friendly health services, including contraception, mental health, STI and blood borne virus prevention, screening and management, and pregnancy choices.[33] [34]

    ii. Young people's access to prevention and health services is further challenged by potential out-of-pocket costs and by their heightened sensitivity around breaches of confidentiality.[35] [36] [37]

iii. Young people of all genders are at risk of sexual assault, especially girls, women, and people with diverse genders and sexualities.[38] Research continues to demonstrate that young Australians are often ill-prepared to navigate safe, healthy, consenting, and egalitarian sexual relationships.[39]

iv. Young people from Aboriginal and Torres Strait Islander communities and those from low socioeconomic backgrounds have disproportionately higher teenage childbirth rates.[40]

v. People with diverse genders, sexualities and variations of sex characteristics have reported lower self-rated physical, mental health and wellbeing than the general Australian population. [41] [42] [43] [44] Young people who identify as sexuality and/or gender diverse and those with innate sex characteristics variations face stigma and discrimination, which makes them vulnerable to increased rates of bullying, harassment, and violence.[45] [46] [47] [48] These young people are disproportionately affected by anxiety, depression, and psychological distress and experience an increased risk of substance misuse, self-harm, suicide ideation and suicide. [49] [50] [51] [52]

vi. Young people from migrant and refugee backgrounds experience language and cultural barriers to accessing sexual and reproductive health services.[53] Migrant and refugee young people are at risk of unintended pregnancies, may have a history of sexual and gender-based violence, [54] and female genital mutilation.[55] Socio-cultural beliefs about sexual health and feelings of shame and stigma attached to sex and sexual health limit migrant and refugee young people's access to sexual and reproductive health services.[56]

vii. Young people with disability do not have adequate opportunities to voice matters affecting their sexual health and wellbeing. Anti-ableist policies in sexual and reproductive health, for example, in education curriculum is key to achieving equitable health outcomes. There is a need for well-designed, disability inclusive education programs that prioritise safety, assertiveness, and self-determination to support positive outcomes. [57] [58]

21. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goal 3 – Good Health and Wellbeing and Goal 10 – Reduced Inequalities.

PHAA seeks the following actions:

22. Governments and other stakeholders work together to develop, implement, and continuously evaluate gender, sexuality, and reproductive health school curricula using an approach that is best practice, implemented whole of school, is student-centred, inclusive, culturally aware, safe, competent, trauma-informed, and rooted in young people's sexual and reproductive health rights.

23. Curricula and interventions must be delivered by trained teachers and reinforced in the community.

24. Collaboration with services such as Aboriginal Community Controlled Health Organisations is required to provide culturally safe implementation of sexual and reproductive health for Aboriginal and Torres Strait Islander communities.

25. Governments (Federal, State, and Territory departments of Health and Education) and other stakeholders (schools across sectors, young people, parents, guardians, families and communities) work together to develop best practices and curricula to address gender and sexuality and to ensure sexual and reproductive health needs and rights of children and young people.

26. Governments and other key stakeholders including but not limited to tertiary education institutions, teacher registration boards, school boards, and school administrations must ensure adequate funding, training, resources and support for people with diverse genders, sexualities and variations of sex characteristics, and reproductive rights-based school curricula founded on best available health evidence.

27. In line with key Government frameworks, e.g., Australian Student Wellbeing Framework,[59] a whole school community-based approach is required, including up-to-date and relevant curricula, classroom instruction, supportive environments, and consultations with content experts. The curriculum must be evidence-based, of sufficient duration, incrementally delivered from kindergarten (according to age and developmental stage of students), meet the needs of diverse young people, and include respect and consent education.

28. Governments and other stakeholders provide adequate support mechanisms for all children and young people, acknowledging that children and young people grappling with their gender identity, sexuality, and/or sex characteristics and their parents/carers may require referrals to specialist support services.

PHAA resolves to:

29. Advocate for the above steps based on the principles in this position statement.

30. Embed principles of inclusion when addressing the health of people of diverse gender, sexuality, and variations of sex characteristics regarding reproductive health, and the rights of young people through the lens of intersectionality into all PHAA policy development and assess the impact and implications of any planned policy action.

31. Ensure that all children's and young people's interests are equitably represented in organisational approaches and activities.

32. Advocate for and support the development and funding of robust research and evaluation frameworks to build evidence for inclusive and rights-based practices that are relevant and cater to the experiences and needs of all young people.

33. Encourage various special interest groups within the PHAA to work collaboratively to promote the visibility of people with diverse genders, sexualities and variations of sex characteristics and reproductive health-related research, evaluation, and best practice for and with young people and disseminate these findings and learnings.

34. Seek opportunities to engage with Departments of Education to advocate for the rights of young people.

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(This policy was developed and co-authored by Dr Cristyn Davies (Child and Youth Health Special Interest Group) and Dr Sowbhagya Micheal (Diversity, Equity and Inclusion Special Interest Group) in consultation with a range of stakeholders within and outside of the PHAA. PHAA also acknowledges the following individuals for contributing to this statement - Associate Professor Jacqueline Ullman, Professor Iva Strnadova, Morgan Carpenter, Betty Nguyen, Jenon Castro, Jessica Nguyen and Jennifer Nguyen.)

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