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Editorial

Let's talk about sex: gender norms and sexual health in English schools

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The sexual health of young people in England is an urgent public health concern. Teenage pregnancy rates have declined but remain the highest in Western Europe and are associated with health, social and economic problems, even after adjusting for pre-existing disadvantage. Rates of sexually transmissible infections (STIs) remain high. If undiagnosed, these have important consequences for later fertility and health. Sexual violence against women and girls is a major sexual health concern and a growing body of evidence suggests sexual harassment and assault, female genital mutilation and rape are common experiences had by women and girls in England.[1,2] While interventions to address young people's sexual health have focussed on knowledge, skills and contraception access, amazingly none in the UK has explicitly addressed the effects of the social hierarchies of gender and gendered behavioural ideals that shape young people's sexual expectations, attitudes and behaviour. The lack of attention to gender is a persistent gap in health research, practice and policy.

Research suggests a link between rigid and inequitable gender norms and negative sexual health in terms of partner violence, teenage pregnancy and STIs.[3–8] Gendered power imbalances in sexual relationships may constrain young women's ability to negotiate safe and pleasurable sex. A US cross-sectional study showed that women with high levels of power in their intimate relationships were five-fold as likely as women with low levels to report consistent condom use, after controlling for sociodemographic and psychosocial variables.[9] This study estimated that over half of the lack of consistent condom use among women can be attributed to low sexual relationship power.[9] Another cross-sectional study of 5913 adolescents aged 14–18 years in 20 secondary schools in Bolivia and six secondary schools in Ecuador showed that sexually active adolescents who consider gender equality important report higher use of contraceptives, are more likely to describe their last sexual intercourse as a positive experience and consider it easier to talk with their partner about sexuality compared with sexually experienced adolescents who are less positively inclined towards gender equality.[3] These correlations were consistent for boys and girls. Non-sexually active adolescent boys and girls who consider gender equality to be important are also more likely to: (i) think that sexual intercourse is a positive experience; (ii) consider it less necessary to have sexual intercourse to maintain a relationship; and (iii) find it easier to communicate with their girlfriend/boyfriend compared with sexually non-active adolescents who consider gender equality less important.[3] Furthermore, findings from 10 studies in Latin America, Asia and Africa found significant associations between support for inequitable gender norms and increased risk of partner violence and unprotected sex.[6,7]

Qualitative research suggests that pervasive norms about how males and females are supposed to behave can affect sexual risk behaviours; for example, young women may be unwilling to carry condoms or request their use because of the implication that they are sexually promiscuous.[10] Young women may feel pressure to engage in early and unprotected sex because of an expectation that they seek male commitment to relationships.[10–12] Similarly, young men are expected to always be ready for sex and the demonstration of sexual prowess is often associated with seeking multiple sexual partners. Condom use is commonly regarded as interfering with perceived masculine attributes of spontaneity, risk taking and with conceptions of what is 'good sex'.[13–16] In addition, while there is increased popular acceptance in some cultures of same-sex partnerships, there is ongoing marginalisation associated with sexual minorities and this is illustrated in the disproportionately high rate of suicidal thoughts and suicide attempts among young people who are lesbian, gay, bisexual or transgender.

Gendered power imbalances also result in girls' experience of gender-based violence and sexual victimisation.[17–19] A recent UK survey showed that nearly three-quarters of 1288 girls aged 13–21 years admitted to having suffered sexual harassment; 75% of girls aged 11–21 years think sexism affects most areas of their lives; and 28% of 13–21-year-old girls experience unwanted sexual touching at school.[1] The normalisation of sexual coercion is echoed in the results of the most recent British sexual attitudes and lifestyle survey (Natsal 3), which showed that one in 10 women admit to have been forced into

having sex against their will and one in five women experienced attempted sex against their will.[2] These experiences could happen at any age, but were more common at younger ages.[2] The Natsal 3 study also found that people who said they had experienced sex against their will were also more likely to report harmful health behaviours and poorer physical, mental and sexual health.[2]

There is increasing recognition of the importance of unequal gender norms in adverse sexual health. The World Health Organization emphasises gender as an 'upstream' determinant of young people's sexual health behaviour and recognises that attending to inequitable gender norms is key to realising sexual and reproductive health and rights. Such recognition has informed recent demands that sexual health interventions address gender inequities.[19]

Schools are a key battleground for such work. Brook (https://www.brook.org.uk/about-brook/brook-position-statement-relationships-and-sex-education, verified 23 Feb 2015) and other leading health and social advocates (https://www.pshe-association.org.uk/content.aspx?CategoryID=1053, verified 23 Feb 2015; http://www.sexeducationforum.org.uk/policy-campaigns/sre-its-my-right.aspx, verified 23 Feb 2015) in the UK have pointed to the limitations of current sex education in schools, which is statutory only in so far as it is included in the national science curriculum. Such provision focuses narrowly on the mechanics of reproduction, body parts, puberty (and for secondary schools, HIV and STIs) and generally neglects issues of gender and equity. Outside the science curriculum, schools can offer as much or as little sex and relationship education (SRE) as they choose – and this can mean none at all. The current provision neither protects nor empowers young people.

The UK Parliament's Education Select Committee is currently hearing evidence for and against making personal, social and health education, including SRE a statutory subject. While we are in full support this, we would add that sustained improvements in sexual health are likely to require addressing the gender norms within which sexual identities, beliefs and practices are embedded. Indeed, the extensive experience of Brook working in schools across England shows pervasive gendered realities of sex and sexuality. We suggest that schools should be addressing not only student knowledge and skills via SRE curricula, but also ensuring that the whole school environment is supportive of gender equity and sexual health; for example, by making sure that discipline and pastoral care policies challenge inequitable gender norms.

Research suggests that the socialisation of norms supporting gender inequities within schools – for example, schools' permissive practices towards sexual harassment or differential behavioural expectations for boys and girls – reinforce and reproduce inequalities.[20–25] But research also suggests practical ways in which such norms may be challenged. A new generation of 'Health Promoting Schools' (HPS) interventions aim not only to provide health education through the school curriculum but also to modify the school social environment and reach out to local communities to promote healthy behaviours including, but not limited to, sexual health;[26] for example, a whole-school multi-component US intervention (Safer Choices) aimed at reducing multiple risk factors for HIV, STIs and pregnancy. Intervention activities included students engaging in peer-to-peer marketing in order to modify school gender and health norms. A randomised trial of this intervention reported that it was effective in increasing condom use by approximately one-third as well as reducing partners with whom unprotected sex occurred. The intervention also improved HIV and STI knowledge, self-efficacy (related to refusing sex and condom use), norms about condoms and communication with parents.[27]

Another randomised trial reported that the Shifting Boundaries intervention was effective in reducing sexual victimisation in US middle schools. One trial arm involved an intervention combining an education curriculum (addressing laws and consequences of sexual violence, the social construction of gender roles and healthy relationships) with an environmental component, which included school restraining orders, higher levels of faculty presence in unsafe 'hot spots' mapped by students and posters to increase dating violence reporting. This was effective in reducing sexual violence victimisation involving peers at 6-months post intervention. A trial arm involving only the environmental component was reported as effective in reducing sexual violence perpetration by peers and dating violence.[28] While such interventions appear promising, none have been evaluated in the UK.

Informed by the HPS framework, previous studies, as well as theories of gender, we suggest the need to develop and rigorously evaluate comprehensive gender-based sexual health intervention in UK secondary schools. These should combine SRE within schools' personal, social, health and economic education and wider curricula; school-level review of policies and practices to ensure these are supportive of gender equity; and empowering all students to engage in social action to promote their self-efficacy and challenge inequitable gender norms in the school environment and broader community.

A rigorous evaluation of such an intervention package would go some way to building an evidence base for challenging gender norms, which appear to be strongly associated with adverse sexual health outcomes.[3–8,19] The evidence reviewed above suggests such programs could achieve reductions of approximately one-third in outcomes such as sexual violence and unprotected sex. From the education perspective, initiatives addressing young people's sexual health and wellbeing, even if they are evidence-based, may simply be window dressing until broader education policy becomes less grimly 1950s in orientation and starts again to harness schools' potential in developing socially aware and healthy citizens. Generally, a wider commitment of envisioning gender inequity as not just a women's issue, but a public health and development concern to all is needed.

Conflicts of interest

None declared.

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