WINSTON CHURCHILL MEMORIAL TRUST

Burdett Trust for Nursing

Winston Churchill Memorial Trust Fellowship Report

Parental approaches to teaching children about puberty, relationships and reproduction in the Netherlands.

Dr Clare Bennett (DNurs, MA, PGCHE, BSc (Hons), DipN, RGN)

Winston Churchill Fellow 2017

Contents

Acknowledgements

To be awarded a Fellowship by the Winston Churchill Memorial Trust and The Burdett Trust for Nursing is an incredible privilege and I am honoured to have received this investment; thank you. Thank you too to colleagues in the UK who were so generous in providing me with guidance throughout the application process, specifically Professor Lisa Jones of the University of Worcester and Dr Carolyn Blackburn of Birmingham City University. Equally, I am indebted to colleagues who shared their networks in the Netherlands with me, these are: Dr Peter Unwin, Dr Janice Clarke, Dr Simon Evans, Ruth Jones OBE and Catherine Hyde of the University of Worcester, Dr Nita Muir of the University of Brighton and Dr Judith Carrier and Emerita Professor Lesley Lowes of Cardiff University. I did not have any Dutch contacts until applying for the Fellowship but my colleagues' networks put me in touch with some fantastic people based in the Netherlands who enabled me to recruit to the study. I wish to thank Arris Lueks and Ben Bartels of Hogeschool van Arnhem en Nijmegen (HAN) University of Applied Sciences, Professor Martine Noordegraaf and Jan Willem van Nus of Christelijke Hogeschool in Ede, Dewi Stadwijk of Avans Hogeschool of Applied Sciences in Den Bosch, Aryanti Radyowijati of Results in Health, Professor René van Leeuwen of Viaa Christian University of Applied Sciences in Zwolle, Professor Nick Crofts of Melbourne University, Adriana Grimme of Hanze University of Applied Sciences in Groningen, Dr Simone de Bruin of National Institute for Public Health and the Environment in Bilthoven, Dr Thijs Fassaert of the GGD in Amsterdam and Dr Fleur Thomese of Vrije Universiteit in Amsterdam, all of whom helped me to recruit parents to the study. In addition, Arris Lueks of HAN, Elisabeth Boerwinkel of GGD in Amsterdam, Ilse Peters of GGD regio Utrecht, Elsbeth Reitzema of Rutgers, Elly van der Gouwe-Dingemanse of Driestar educatief and Lisette Schutte of Soa Aids provided invaluable insights from the 'expert' perspective for which I am sincerely grateful. Finally, I wish to thank the thirteen mothers and nine fathers who welcomed me into their homes or met me at their local university to share one of the most intimate aspects of parenting with me. You taught me so much, both as a researcher and as a mother; I cannot thank you enough.

Cover photo credit: Fotolia. All other photos taken by Clare Bennett.

Abbreviations and glossary

HIV	Human Immunodeficiency Virus
STI	Sexually Transmitted Infection
SRE	Sex and Relationships Education
UK	United Kingdom

Biography

I qualified as a Registered General Nurse in Birmingham, England, in 1992 and very quickly developed an interest in HIV and sexual health promotion. First, I worked with children and babies who were HIV positive in Romania and later with young people and adults, at the West Midlands Regional Centre for HIV. I then went on to work in Sexual Health before becoming a Research Nurse at Birmingham University and a Clinical Nurse Specialist in Immunology for the West Midlands Regional Immunology Centre. In 1999 I moved to London where I continued to practice clinically and commenced my academic career. My first post was with Middlesex University, followed by the Royal College of Nursing Institute, the Open University, the University of Worcester and more recently, Cardiff University. Throughout this time I have continued to develop my clinical interests in HIV and sexual health through teaching and research. In 2016 I completed my Doctorate at Cardiff University which focused on the role of fathers as sexuality educators for their children in England. I have since gone on to publish from this study and I have also carried out research on mother-child sexuality communication in England. Most recently, I have undertaken this Winston Churchill Travel Fellowship which builds on my doctoral research and is the focus of this report.

Executive summary

Against a backdrop of increasing sexually transmitted infection amongst young people and comparatively high rates of unintended teenage pregnancy in the UK, this project sought to learn how Dutch parents teach their children about puberty, relationships and reproduction. The Netherlands was chosen as the study site since it has been evidenced that their open, partnership approach to sexual health promotion is effective in reducing such outcomes.

Nine fathers and thirteen mothers of children aged ten years and under and six experts participated in one-to-one interviews at various geographical locations throughout the Netherlands. The findings centred on five principal themes:

- The parents' commitment to parent-imparted sexuality education
- Parental comfort in discussing sexuality and bodies
- High levels of self-efficacy and confidence amongst the parents regarding their role as early sexuality educators
- Perspectives on childhood that respected the child's autonomy
- The normalisation of sexuality communication

Comparisons with equivalent data from England suggested that Dutch parents enjoyed much greater openness than their English counterparts when they learnt about sexuality themselves, as children. This, as well as supportive governmental messages, the normalisation of sexuality communication and the availability of wide-ranging resources, appears to have led to greater confidence, commitment and ease, on the part of the Dutch parents, in discussing relationships and sexuality with their children. The data also suggested that the Dutch fathers were more involved in their children's learning about sexuality than the cohort of English fathers. Furthermore, in contrast to the English parents, the Dutch mothers and fathers asserted that sex education posed no threat to childhood innocence.

The findings suggested that the Dutch approach to sexuality education upholds the rights of children in this regard but in the UK the amount and quality of relationships and sexuality education that children receive is highly variable. The recommendations following this Fellowship are, therefore, as follows:

- Sexology and Health Science Honours Degrees and Masters programmes should be developed as specialist subjects in UK Higher Education Institutions (HEIs).
- The commissioning of sexual health promotion services should be orchestrated at the national level.
- Schools based sex education should be underpinned by an evidence base.
- Schools should work in partnership with parents to support them in developing their skills in parent-child sexuality communication.
- Early parent-child sexuality communication should be promoted.

Introduction to the project

Background

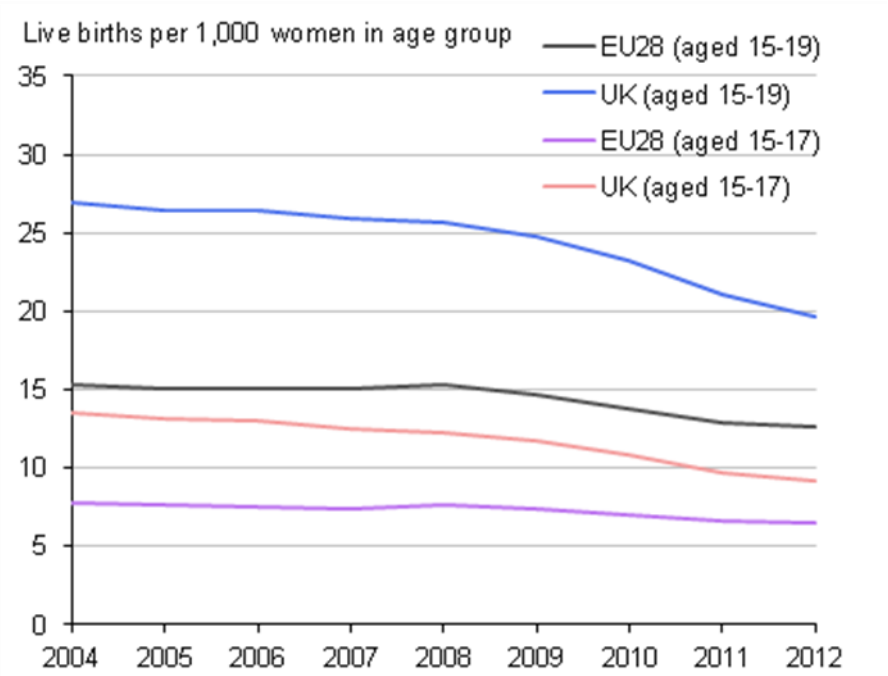
Young people throughout the UK are engaging in sexual intercourse at a younger age (Mercer 2013; WHO 2012) and have a higher number of concurrent partners (Health Protection Agency 2012) than previous generations. As a consequence, 16-24 year olds are increasingly experiencing higher rates of sexually transmitted infections (STIs) and unintended pregnancy than any other section of society (Public Health England 2017, Health Protection Agency 2009). Indeed, although 16-24 year olds represent only 12% of the population they account for more than 50% of England's STI diagnoses (Public Health England 2017; Health Protection Agency 2012). Equivalent data for Wales (Public Health Wales 2017), Scotland (FPA 2016) and Northern Ireland (FPA 2016) suggests that these trends are widespread throughout the UK.

The physical and psycho-social ramifications of STIs problematize these statistics since the potential impacts are very significant both for the individual and society as a whole. Physically, STIs such as chlamydia and gonorrhoea can lead to infertility; syphilis can cause blindness, deafness, loss of muscle control, seizures and dementia; HIV is associated with significant morbidity and mortality; and certain strains of human papillomavirus are associated with various cancers (Shepherd et al. 2010). STIs in pregnant women can lead to miscarriage, pre-term birth, stillbirth, serious eye infections, neonatal pneumonia, systemic disease and physical deformity and HIV can be transmitted from mother to baby (Shepherd et al. 2010). In addition, the diagnosis of a STI commonly leads to negative emotional and psychosocial consequences (Nack 2008), feelings of anger and embarrassment (Royer and Cerf 2009) and anxiety regarding the impact of the STI on current and future relationships (Melville et al. 2003). At the macro level, STIs also incur substantial economic costs (CDC 2016; Lucas 2013).

Although pregnancy rates amongst under 18 year olds in England have fallen (Office for National Statistics 2017) the UK has the highest birth rate for girls aged 15 to 19 across Europe. Between the years 2000 and 2012 per 1,000 of the 15 to 19 year old female population the Netherlands had a rate of 5, Italy had 7, Germany had 10, France had 11 and the UK had 26

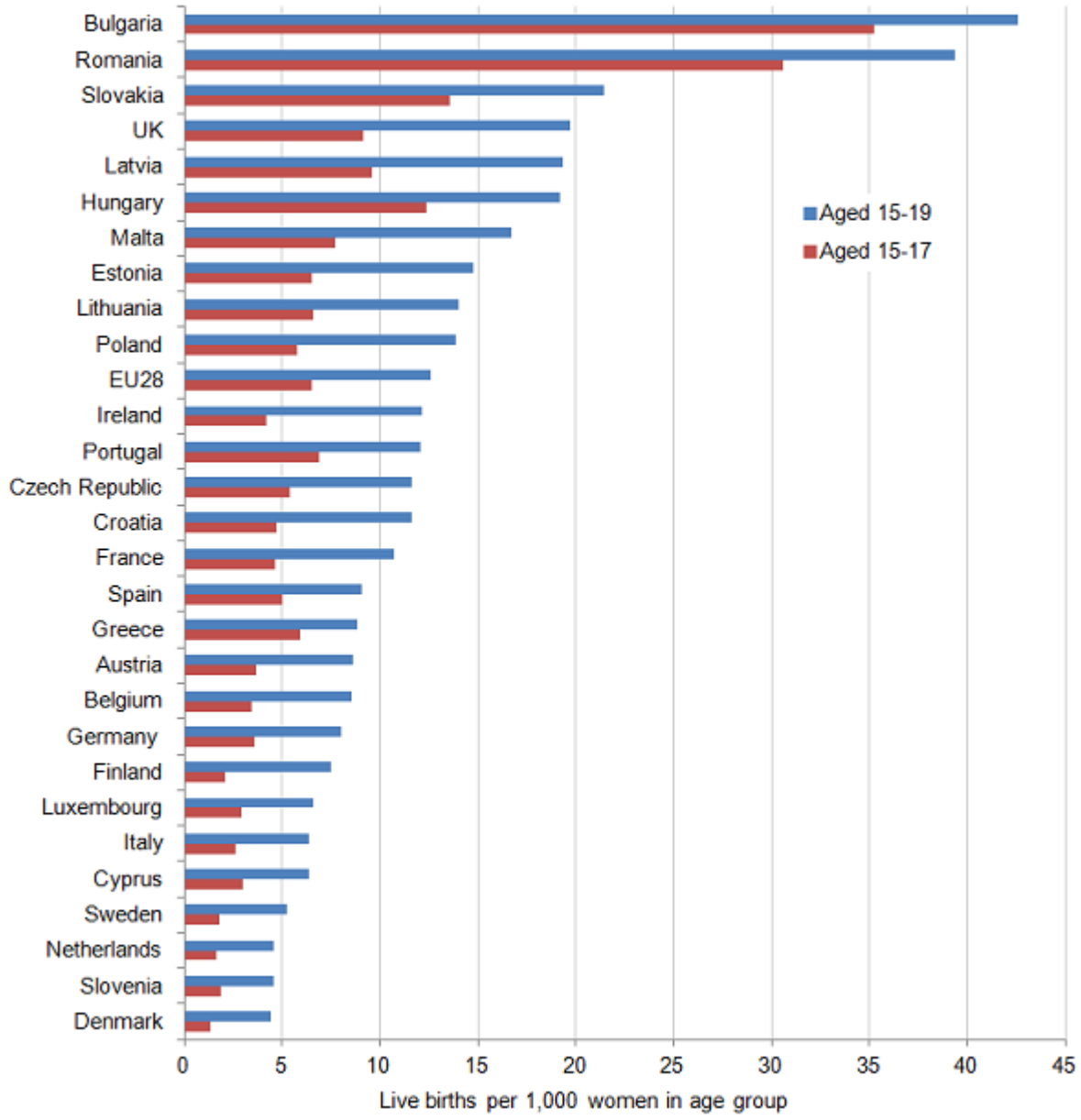
(UNICEF 2012). Additional statistics demonstrate that the UK ranks poorly against the European Union as a whole (EU28) as well as against comparable European countries as demonstrated in figures one and two (Office for National Statistics 2014).

Figure one. Live birth rate (per 1,000) to women, in United Kingdom and EU28, 2004-2012.



Similarly, Sedgh et al. (2015) identified that for pregnancies amongst 15 to 19 year olds, international data ranked England and Wales 19th out of 21 countries with complete data, with 47 per 1000 per annum. Whereas the Netherlands was ranked second lowest, at 14 per 1000 per annum. For births, England and Wales was among the highest European rates at 21 births per 1000 15 to 19 year olds and the Netherlands was the second equal lowest rate in Europe with 5 per 1000.

Figure two. Live birth rate (per 1,000) to women aged 15-19/ 15-17 in EU28 countries, 2012



Adolescent pregnancy and childbirth continues to be regarded as a significant contributor to maternal and child mortality as well as to cycles of compromised health and poverty. This is underpinned by socio-economic factors before and after pregnancy rather than the biological effects of young maternal age (Office for National Statistics 2014). For example, young women in westernised cultures who have a baby during adolescence commonly experience a number of challenges such as abandonment by parents, difficulties in completing their education and economic hardships (Kosunen et al. 2002, Department of Health 2004). In turn,

their children are more likely to experience lower educational attainment, economic hardship and females are at higher risk of becoming teenage mothers themselves (Department of Health 2004). Thus, early sexual debut and the associated risk-taking is of significant concern in the UK.

International comparative data is limited regarding the sexual practices of young people but we know that in the UK at the turn of the millennium, 40% of 15 year olds reported having had sexual intercourse compared to 15-20% of 15 year olds in other Organization for Economic Cooperation and Development (OECD) countries (UNICEF 2007). More recently, the third National Survey of Sexual Attitudes and Lifestyles (Mercer et al. 2013) revealed that median age at first heterosexual intercourse in the UK is 16 years among 16–24 year olds and among this age group, 31% of men and 29% of women now have first sex before the age of 16. In contrast, in the Netherlands a recent study (Rutgers and Soa Aids 2017) of 20,500 young people aged 12 to 25 years revealed that at the age of 18.6, half of young people had had sexual intercourse. When they do have sex, a joint study of Rutgers and STI Netherlands found that over 7 out of 10 Dutch adolescents used a condom the first time, and World Health Organization data shows that Dutch teens are among the top users of the birth control pill.

Approaches to sexual health promotion

In the UK, considerable investment has been made in young people's sexual health promotion but systematic reviews suggest that traditional pedagogic approaches have had limited impact (Lazarus et al. 2010; Shepherd et al. 2010). The focus of health promotion has, therefore, shifted towards strategies that aim to increase young people's self-efficacy and resilience (Department of Health 2013; AYPH 2016). One particular approach to addressing young people's self-efficacy and resilience is parent-child sexuality communication since there is a growing body of research that suggests a protective relationship between open parent-child sexuality communication and young people's sexual decision making (Flores and Barroso 2017; Widman et al. 2006, 2016; Campero et al. 2011; Nagamatsu et al. 2008; Ogle et al. 2008; Huebner & Howell 2003; Miller et al. 2001; Lehr et al. 2000; Somers & Paulson 2000). However, research suggests that parents in the UK often struggle to provide effective,

accurate and timely sexuality education for their children in general and pre-adolescent children in particular (Stone et al., 2015a, 2015b, 2013).

In contrast, research (Lewis and Knijn 2001, Sheldon 2018) suggests that Dutch parents tend to embrace a more open approach to the subject than their UK counterparts and it is thought that this may, in part, explain the difference in young people's sexual decision making.

Aims, objectives and purpose of the project

This project, therefore, set out to learn about how Dutch parents teach their children about puberty, relationships and reproduction. The study built upon existing research in the UK that I carried out for my Doctorate (Bennett et al. 2017a, 2017b; Bennett 2016) and the study was replicated exactly in order to facilitate comparisons between the two sets of parents' practices in this regard. The overarching aim of this project was to inform sexual health promotion strategy in the UK since we are currently at an historic moment with relationships and sex education becoming mandatory across all schools from September 2019, with an amendment to the Children and Social Work Act requiring all secondary schools to provide "relationships and sex education" and all primary schools to give "age appropriate relationship education." Subsequently, discussions regarding how and what children should be taught are becoming more common place and it is intended that this report will contribute to this debate.

We know that open parent-child sexuality communication can delay sexual debut, meaning that sexual risk-taking is reduced, but there is a lack of understanding as to 'how' such openness can be achieved in the UK. It was, therefore, envisaged that an understanding of what 'open communication' means and how Dutch parents approach sexuality communication would inform UK health and care strategies in this regard, with the potential to reduce teenage pregnancy and STI.

The study objectives were, therefore, to:

1. Carry out in-depth, face-to-face, individual interviews with 5-10 Dutch parents of children aged 3 to 10 years, exploring whether the parents pro-actively or reactively raise the issue of sexuality with their children, their style of communication, what they discuss and perceptions of their role.
2. Discuss the findings with 2-5 Dutch academics/healthcare practitioners.
3. Write up the findings including comparisons with existing UK data.

The objectives for knowledge mobilisation were to:

- Provide press releases throughout the project.
- Write a project report.
- Share findings with UK parents via social media.
- Present findings to UK parenting and children's charities.
- Present findings to UK professional networks.
- Write articles for parenting, nursing and academic journals.

- Disseminate findings amongst UK commissioners.
- Develop a website for parents to use as a resource and to share experiences.
- Develop a short resource book for parents to support them in this role.

Methodology and methods

Methodology

This study employed Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, and Larkin 2009) which has a dual aim of providing an in-depth exploration of people's lived experiences as well as an examination of how people make sense of these experiences. By going beyond description and looking for meanings embedded in the parents' experiences as early sexuality educators it was hoped that an insight in to their lifeworld would be possible where the influence of contexts such as personal history, socialisation, culture, peer attitudes and beliefs would be illuminated. In addition, IPA's focus on social cognition, that is 'the relationship between what people think (cognition), say (account) and do (behaviour)' (Smith and Eatough 2012, 442), was of particular value to this research since it was concerned with both the perceptions and practices of mothers and fathers.

Methods

A total of 9 fathers and 13 mothers of children aged 10 years and under were recruited to the study through advertisements placed by professional networks throughout the Netherlands.

All of the parents lived with their children full-time and shared caring responsibilities for the child. Participants were professionals, educated to degree level or equivalent and lived in the Netherlands. Thus, the sample was homogenous; a quality which is advocated for IPA studies since the aim is not to generalise but to facilitate an in-depth exploration of a defined group's or an individual's lived experience of a particular phenomenon (Smith, Flowers and Larkin 2009).

Data collection took place via face-to-face interviews conducted in English in the parents' homes or their local University between 22nd July and 25th August 2017. Locations included a houseboat, apartments, houses, flats, offices and university classrooms at Christelijke Hogeschool in Ede and Vrije Universiteit Amsterdam. In addition, interviews were conducted with six experts in the field. Geographically, data collection took place throughout the

Netherlands including Noordwijkerhout, Ax Hasselt, Ede, Arnhem, Zoetermeer, Amsterdam, Apeldoorn, Utrecht, Deventer, Leiderdorp and Gouda.

A semi-structured interview schedule was used with questions focusing on the parents' beliefs and attitudes regarding how children should learn about physical maturation, relationships and reproduction and how they approached these areas of learning with their children themselves. Interviews lasted between 50 and 130 minutes and took place within the participants' homes or local university. All the interviews were recorded and transcribed verbatim.

Data analysis adhered to Smith, Flowers and Larkin's (2009) guidelines which advocate that analysis should be an iterative and inductive process with each interview analysed separately initially. Each transcript was analysed line by line and initial descriptive notes were made along with observations of the language used and semantic content. Finally, conceptual comments were developed which, in due course, became themes. Throughout the process the concept of the hermeneutic circle (Smith, Flowers and Larkin 2009) was employed with an emphasis on the interplay between the parts and the whole and between the interpreter and the research participant(s) and their story. Smith (2004) draws on Ricoeur's (1970) distinction between the hermeneutics of meaning recollection and empathic engagement and the hermeneutics of suspicion and critical engagement. By engaging both modes of hermeneutic engagement, Smith (2004) argues that a more comprehensive understanding of the participant's lived experience can be gained. This study sought to achieve this depth of interpretative analysis by initially prioritising 'hermeneutics centred in empathy and meaning recollection' and then going on to a 'hermeneutics of questioning, of critical engagement' to allow for a 'more complete understanding of the participant's lived experience' (Smith 2004, 46). This process was cyclical in that emerging themes were tested against earlier data and themes were, on occasion, changed to become subordinate or superordinate. Throughout the process, presuppositions and judgements were suspended through a process of reflexivity, the aim being to focus on what was present in the data rather than what was assumed to be present (Spinelli 2002).

Finally, a cross-group comparison was made to identify areas of convergence and divergence between the parents. To facilitate this process Smith, Flowers and Larkin's (2009) guidance

concerning the use of abstraction, subsumption, polarisation, contextualisation, numeration and function was used in order to establish a deeper understanding of the data.

The Institute of Health and Society at the University of Worcester granted approval for this study and the agreed protocols were adhered to throughout.

Report overview

This report will provide an overview of the themes that emerged through analysis of both the parents' and the experts' data. For the purpose of this report, themes have been presented with minimal theoretical interpretation to aid presentation. Results will be disseminated in the form of a more traditional Interpretative Phenomenological Analysis in the academic publications that form part of the knowledge mobilisation plan. The report will conclude with a reflection on the successes of the project in providing answers to the research question, an examination of the relevance of the project's findings to the UK, recommendations for practice and an outline of next steps.

Findings

The findings of this study were consistent across parents and experts in the field. Findings have, therefore, been synthesised to provide greater clarity and to avoid repetition. Personal observations from living in the Netherlands for five weeks are also integrated where appropriate.

The sample

Nine fathers and thirteen mothers participated in this study. All of the parents were professionals and were educated to at least degree level or equivalent. They all lived with their children and the child's other parent full-time. The gender and age distribution of the children being discussed by the parents is outlined in tables one and two.

Table one. Gender and age distribution of children discussed by mothers.

Age (years)	Boys *(n)*	Girls *(n)*	Total *(n)*
1	0	1	1
2	1	1	2
3	0	0	0
4	2	0	2
5	1	1	2
6	1	1	2
7	3	3	6
8	1	0	1
9	1	2	3
10	2	3	5
Total	**12**	**12**	**24**

Table two. Gender and age distribution of children discussed by fathers.

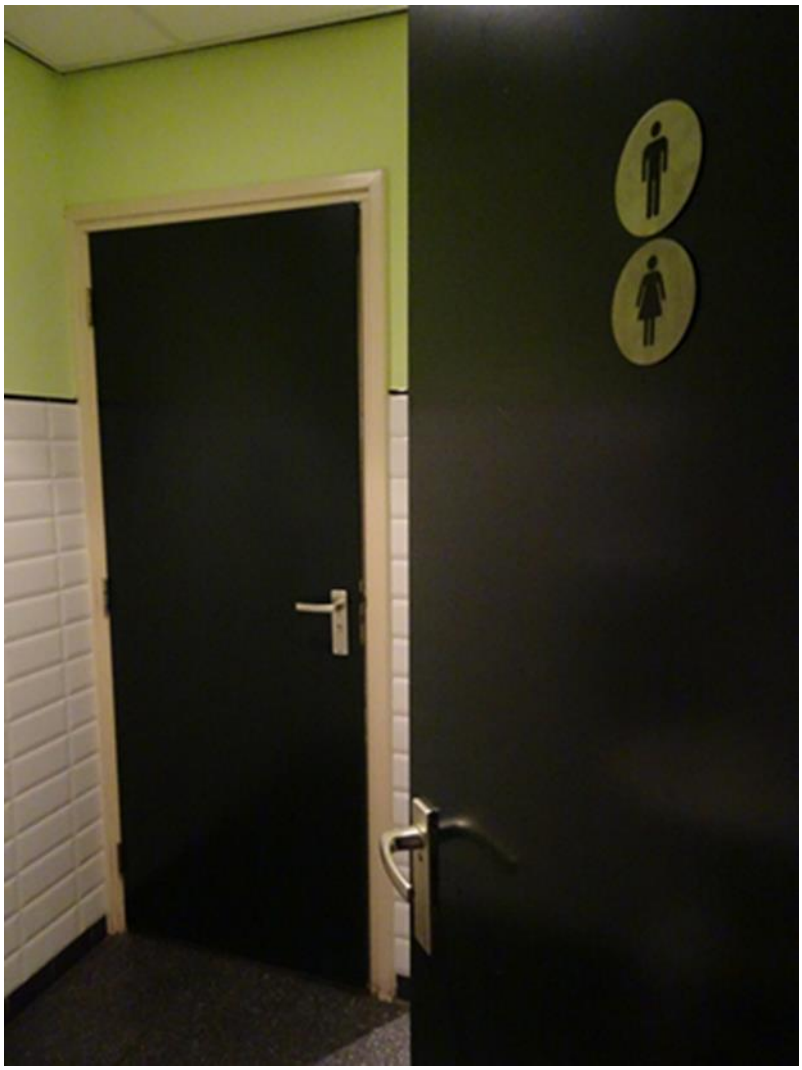
Age (years)	Boys (n)	Girls (n)	Total (n)
1	0	1	1
2	1	0	1
3	1	0	1
4	1	0	1
5	1	1	2
6	1	0	1
7	1	3	4
8	1	0	1
9	1	1	2
10	2	2	4
Total	**10**	**8**	**18**

Theme one: A commitment to sexuality education

Although the parents differed significantly in relation to their religious beliefs, their choices regarding their children's religious upbringing and their personal experiences of learning about relationships and reproduction they were all equally committed to teaching their children about their bodies, relationships, sex and reproduction, regardless of their child's age. Their commitment was underpinned by a belief that open communication is positive for children in relation to them learning to enjoy their bodies, to have positive perceptions of their bodies, to have fulfilling relationships in the future and to know their own boundaries. The parents felt that education and open communication regarding relationships and sexuality was likely to lead to their children making safe choices that were right for them such as abstaining, using condoms and oral contraception and choosing a safe place in which to make love. Although many of the parents articulated that this is not an easy aspect of parenting, it was perceived to be so important that they were determined to overcome any personal discomfort to talk about relationships, bodies and sexuality with their young children. As one mother stated: *'my motivation to give my children the skills that will prepare them for healthy relationships is bigger than my anxiety that surrounds talking about it. So, I try my best and explain everything to them'*.

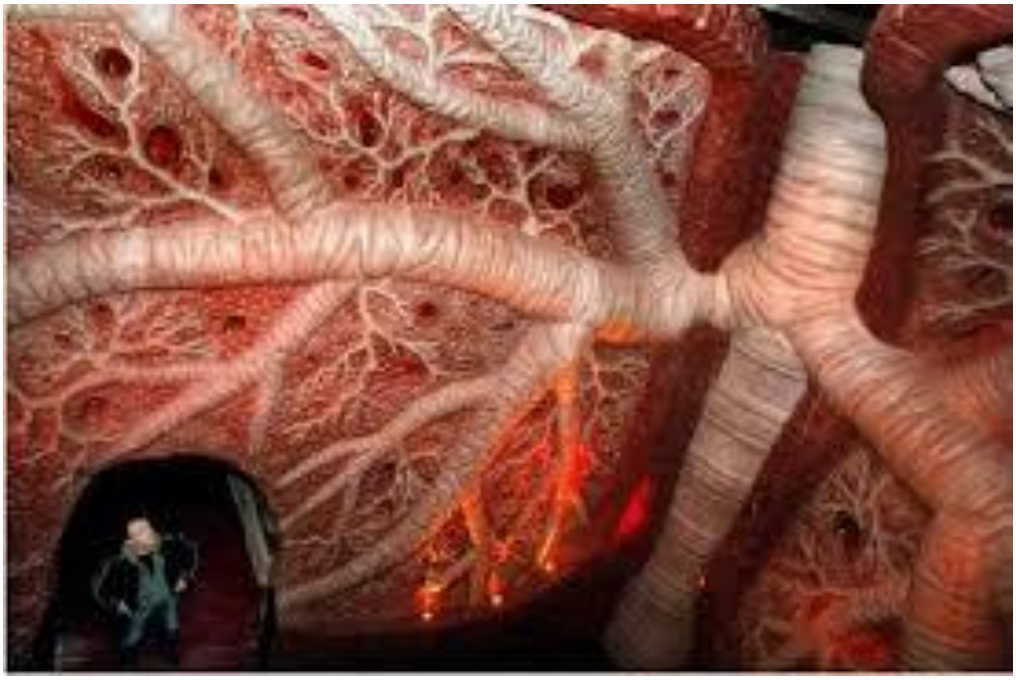
The parents placed significant emphasis on the need for children to be able to assert their personal boundaries and to define what is acceptable and not acceptable to them. This appeared to be supported by a wider movement supported in schools where children are taught to assert boundaries in the playground by saying 'Stop, Hou Op' and signalling with their hand to say 'stop, I do not like that'.

Some of the parents also talked about their children's schools employing coaches who helped children to develop their social skills in the playground, with an emphasis on setting, asserting and respecting boundaries. Although this initiative was not linked directly to relationships and sex education, the parents felt that it was supportive for the children in this regard. For example, one mother said: *'Once you've learned to say stop because you don't want your friend to hit you with a stick, then the next step is to say stop when somebody asks you to have sex and you don't want* to'. All of the parents articulated that boundary setting was very important, since it enabled children to know that they had rights which should be respected by everyone, for example one mother explained: *'At a young age I teach them also, the penis is for yourself, nobody touches it, it's yours'.* All of the parents talked about teaching their children about good touching and not-good touching and how the children should deal with the latter, including in the case of a family member.



Theme two: Body comfort

As a researcher living in the Netherlands for five weeks, beyond the data collection I observed a greater sense of body comfort in general everyday life with a museum devoted to understanding the human body (the Corpus Museum in Leiden), nude beaches at lakes being common place, non-applicator tampons dominating in pharmacies, tampons and sanitary towels commonly visible in baskets in mixed gender toilets and baby changing areas that were not behind closed doors. On a number of occasions, I saw fathers lifting their children up so that they could peep over the top of a changing cubicle in a clothes shop and chat to their mother. In addition, the cycling culture and outdoors way of life appeared to contribute to a greater sense of 'corporeality' or an awareness of the body.



The mothers and fathers talked about sexuality with ease. Within minutes of the interviews commencing they would use words such as vagina, penis and vulva without embarrassment. Several chose to conduct the interviews with their children present and the children were comfortable to sit and ask questions or read the sex and relationships books that their parents had got off the book case shelves to show me. They talked intimately about their children's bodies and the need to support them in learning about their physical selves. Several made reference to siblings teaching each other about their genitalia by showing each other and children learning by asking to look at their parents' genitalia. The parents felt that it was important for their children to see their bodies and each other's as it led to openness and prevented embarrassment. For example, one mother described her ten-year-old son's excitement at showing her and his father his first two pubic hairs. Another mother described her four year old's openness by saying: *'… he also talks about me having breasts and my husband doesn't. So he points at his nipples and he said "They're not going to grow when I get older, right?" We said, "No, only women get breasts, you don't; you're going to look like daddy". "But I want breasts too". "Why?" "Because then I can feed my baby with them … I want to give it something that comes out of me".*

Another aspect of body comfort related to the parent's aspirations for their children to respect their bodies and to consider their bodies as their own. In explaining this, one of the fathers said *'…it starts with belief that if you're willing to have a relationship during your life, you have to be happy with yourself, not only with your mind but also with your body'*. The father related this, in part, to the education system in the Netherlands where emphasis was placed on personal space, positive and inappropriate touching and boundary setting.

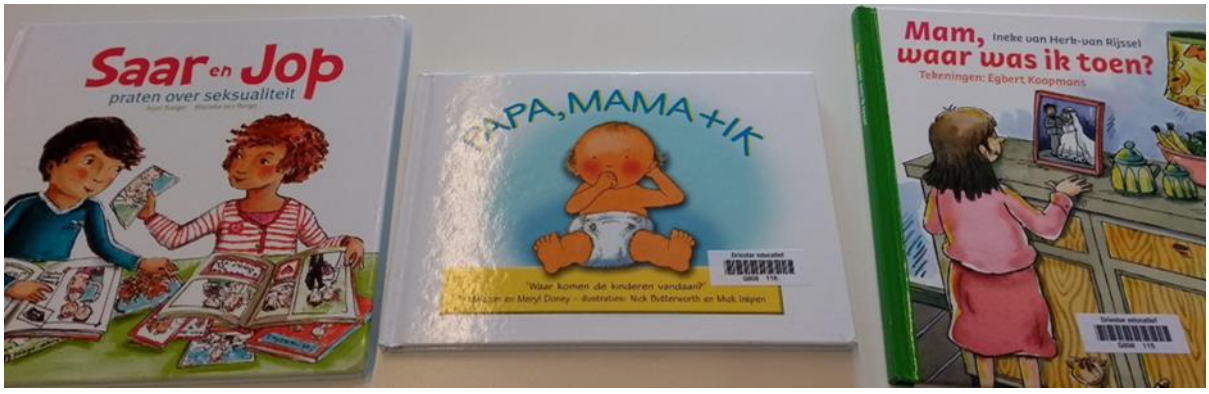
Theme three: Self-efficacy

The parents were, on the whole, very confident in their ability to educate their children about relationships, their bodies, sex and reproduction. Amongst those who were less confident, the plethora of resources available to them boosted their perceived abilities in this regard. Parents referred to the many and varied books available to them in bookstores and the teaching materials available to them with the most frequently cited being those by Rutgers which is an international centre of expertise on sexual and reproductive health and rights founded and based in the Netherlands. It is funded by the Dutch Ministry of Health, Welfare

and Sport as well as private sources and carries out and disseminates sexuality related research and produces an extensive range of resources to support schools and parents in imparting sexuality education. Examples include these resources that are designed for children up to the age of 12 and these resources for parents. Parents also reported school-based sex education and the associated briefing meetings to be very supportive in this regard.

Additional resources that parents and experts alike referred to in normalising parent-child sexuality communication included their local health facilities, this website for parents about general aspects of parenting, this website specifically about sexual education for children aged 0-12 years as well as this site for parents with children of 12 years and older. Websites that some parents had accessed for their older children included those by Dokter Corrie although there was some debate about the age appropriateness of the videos for primary school aged children amongst the parents. An overview of the videos available can be found here. Specific videos that experts and parents made reference to included body check, tips and tricks, first times and the double nude game. Kindertelefoon, which is an organization

that children can telephone with questions or if they want help in difficult situations also has a website for children as well as specific resources, for example about being in love and your body. Other locally produced websites referred to by the parents and experts included this website and this information site for children. In addition, parents were aware of web resources that would be useful for their children as they reach secondary school age such as SoaAids which focuses on sexual health, SENSE which focuses on relationships and sexuality, Spraying and Swallowing which is a drugs and sex ABC website and the Long Live Love teaching package for secondary schools.



The parents described a mixture of being reactive to their children's questions and proactive when required, for example one mother said: *'Well maybe if I think it is needed, I will throw out my line to him, to trigger him.*' In general, with the younger children the parents appeared to adopt a more reactive approach by responding to their curiosity and their questions, whereas the parents of the ten year olds wanted to be sure that their children were fully cognisant of the various facets of sexuality and would be more proactive if they felt that it was required.

The parents' confidence in educating their children about sexuality in its broadest sense was remarkable and extended to their ability to discuss different types of relationships such as same sex relationships, bisexual relationships and heterosexuality. As one mother summarised, the consensus appeared to be: *'… love is love and it's a free choice'*.

Theme four: Perspectives on childhood

My general impressions of life in the Netherlands suggested that Dutch children have greater autonomy and more freedoms than children in the UK. Sports camps for children and young people that I came across appeared to be less risk averse than equivalent camps in the UK. Children shared busy cycle lanes with adults without the need for a separate lane and I saw many children, approximately age 7 upwards, walking or cycling to and from friends' houses and school independently. Children were very much integrated into everyday life, for example I frequently saw fully equipped baby changing stations with free nappy bags and wipes in cafes and children appeared to be central to community events.

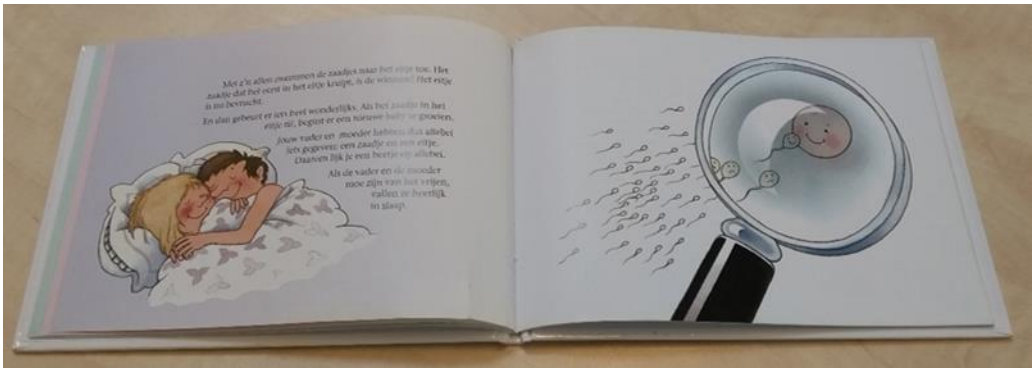
The parents did not have fixed perceptions regarding a minimum age for their children to have sexual relationships. The emphasis was, instead, placed on the child's individual developmental progress and their emotional readiness. Rather than boundaries based on age, a key concern for the parents was mutual respect in terms of children respecting their own bodies and emotions as well as those of others and vice versa. Several parents also talked about the importance of love, for example: *'I want them to learn that sex is never*

separated from love, and that they know that it's about the whole package. That yes, of course you can have sex with everybody, but then you don't get the full experience, and the safest way, and also the most complete and most satisfying way is to have it as a part of a loving committed relationship'. However, this emphasis was not uniform with other parents asserting that they would be happy for their boys and girls to engage in casual sex as long as they were physically safe and emotionally ready. There was a consensus though that by commencing the conversation early, the parents believed that they were setting the foundations for positive attitudes and shaping their children's sexual decision making during adolescence.

The parents emphasised the need for age appropriate information and described a staged approach to imparting information. For example, in describing sexuality communication with her six year old one mother explained: *'The younger one* [age six] *asked me "Oh mum you've got blood from your bottom" and then I'll say "Well it's a girl thing, when you're big enough I'll explain"'* where as she had fully explained the menstrual cycle to her ten year old son. The majority of parents adopted this approach with them introducing the notion of boys' and girls' and mummy's and daddy's bodies, developmental changes and differences in bodies during the pre-school years, then progressively as the child develops more detailed discussions regarding relationships, boundaries, physical development, sex and reproduction taking place. Amongst the parents of ten-year-old children the emphasis was on equipping their children to understand their changing bodies as they progress through puberty so that they embraced rather than feared the associated mood changes and physical development.

Many of the parents emphasised the differing perceptions of children's understandings regarding sexual relationships and adult understandings. As one mother explained *'for children sex is just facts, like learning about the sun and the moon. Talking about sex will not*

make them horny. It means something else, so we should not be afraid'. Another mother showed me the picture on the previous page from a relationships and sex education book for young children which shows the mother and father making love; she commented: *'I was surprised that the children did not have so much attention for it but no interest at all, it's all just facts'.* Similarly, one of the fathers described his six-year old's response to him explaining a picture of a boy applying a condom as simply *'Okay that's it'*.



Theme five: Normalisation

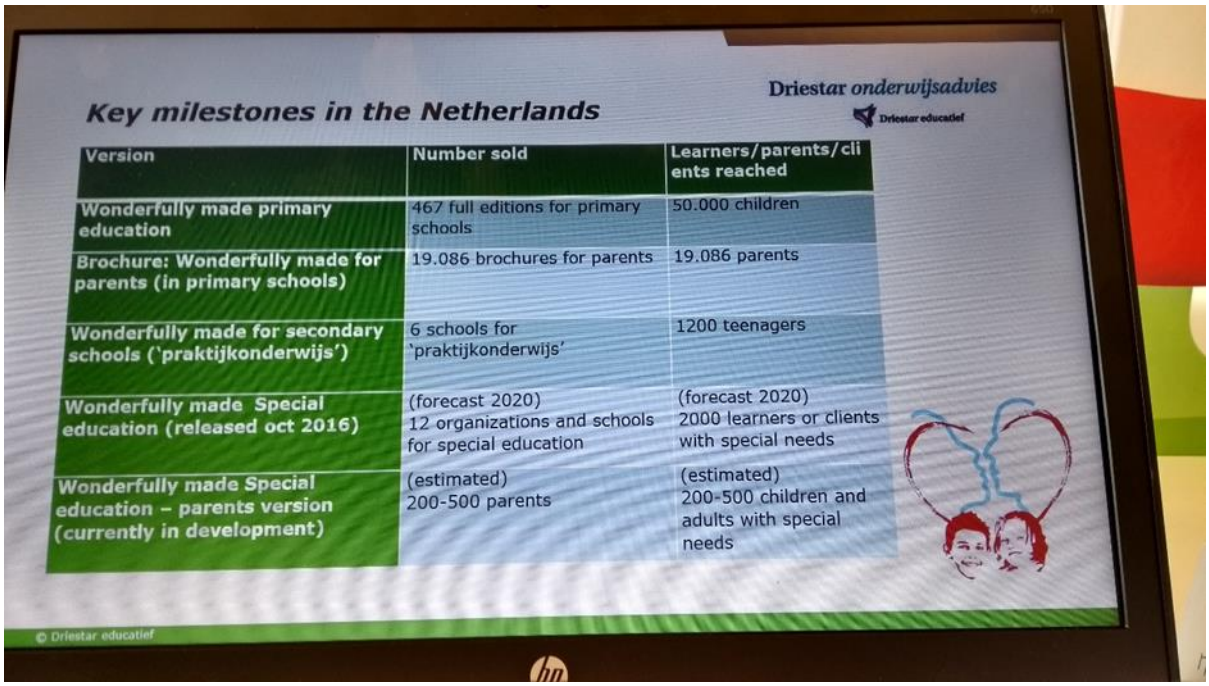
All of the parents alluded to the challenging nature of parent-imparted sexuality education and several suggested that some Dutch parents avoid such conversations. However, the parents asserted that, for the majority, sexuality communication across society has been normalised meaning that it is no longer a taboo. The parents cited television programmes and advertising campaigns being supportive in normalising sexuality communication and they all made reference to Rutgers.

One of the mothers of children aged six and ten described sexuality communication as feeling *'as normal as cooking tea'*. Another who had a child under two and another aged four said: *'I just want to be open about sexuality, that it's a normal part of life … So they see me and their daddy naked …* I *want to teach them that it's an integral part of life and there's a lot more to sexuality than just sex, so that's why I'm already talking about it*'. Several parents had told their pre-school age children how babies are made, for example one mother described how her four year old understood that *'sperm comes from the penis and the egg from the mother, and he just asks, "Okay how do they get together?" And so I explained to them about erections, penetration and ejaculation and for him it's just, "Okay, that's fine, that's cool"'.* Parents also talked about the importance of calling the sex organs by the correct

name, with one mother explaining that her daughter would use the term ‘vagina’ at the age of one and a half.

Several parents talked about their desire for sexuality communication and sex to not become *‘a thing’* for their children. As one mother said: *‘by not making a big thing out of it they think it’s normal and they’re not that curious, so they really don’t need to experiment’*. Another described that she had, so far, managed to achieve this in describing her children’s response to her telling them that she had been in a same sex relationship in previous years as: *‘It was not a thing, no, it was normal’.*

The majority of the parents identified that their children's schools had been instrumental in supporting them in engaging in sexuality related dialogue with their children but this was not uniform with some parents stating that there had been very little sex and relationships education provided through the education system. Four parents described a Christian orientated relationships and sexuality programme called 'Wonderfully Made' by Driestar Christian University in Gouda. The programme has been developed from a Christian perspective and addresses sexuality, relationships and the development of protective behaviours which focus on biblical values and norms and has significant popularity in religious schools across the Netherlands as outlined in the slide below. One of the parents praised the programme, one felt that it helped to stimulate conversations at home and two questioned the programme since they were opposed to some of the messages regarding sexual relationships beyond the heterosexual married couple.



Ten of the parents were familiar with Rutgers' Spring Fever programme which is a Relationship and Sex education programme tailored to the sexual development phases of children aged 4-11 years. The majority of schools in the Netherlands employ Rutgers' sexuality education packages. The programme is characterised by a positive approach to sexuality and starting the discussion at an early age. It takes place in the third week of March, this year it will be 19-23rd March 2018, with teachers in participating primary and special schools across the Netherlands providing a week of teaching about resilience, relationships

and sexuality using specific resources designed by Rutgers. The aim is that the project week will act as a catalyst for structural embedding of the themes in the school's general teaching programme. An overview of an earlier version of the teaching package is available here along with specific resources regarding female genitals, male genitals, menstruation, puberty in girls, puberty in boys and reproduction. The parents whose children had had experience of the programme found it helpful in developing their children's comfort in discussing the various facets of sexuality but two expressed a desire for the programme to become more widely embedded into the school curriculum.

Several of the parents felt that parent-child sexuality communication had been normalised in the Netherlands as a result of a multi pronged approach with governmental messages promoting open communication and schools and healthcare professionals providing support for parents in this regard. In turn, the parents all reported that this made it easier to discuss such issues with their children's friends' parents and they could, therefore, offer each other support. One example given by a mother related to a question that her friend's son was perplexed by *'... until what age does the penis grow? ... We didn't know, so we searched it on the internet together ...'*.

From the child's perspective the parents felt that all of this support led to a well rounded, comprehensive education regarding relationships and sexuality for their children. Certainly the research carried out by Rutgers would support this as suggested in this video. It was acknowledged, however, that despite all of this support children may still be reticant in discussing these issues with their parents, for example one father who had been very open with his son about his changing body explained that although he knew that his son had learnt about reproduction at school he could not bring himself to discuss it with his father.

Comparisons between Dutch and English parents' approaches

The data from my doctoral research with eight mothers and eight fathers residing in England identified an overarching theme of silence which appeared to be underpinned by tensions relating to: 'Childhood Innocence', 'Sexuality: An Enduring Taboo' and 'Aspirations and Realities'. However, none of these themes emerged in the Dutch data.

On the whole, the Dutch parents described much greater openness regarding their personal learning about sexuality from their parents compared to their English counterparts. For example: *'I had a really open relationship with my mum and dad … we all went into the bath tub together, there was no shame …and then my mum told me about when menstruation came, how the body works and yes, by seeing each other nude also, I'd seen boobs and other stuff and so there was no barrier for asking'.* This appeared to be generational with their descriptions of their grandparents' lack of sexuality education resonating more with the experiences of the English cohort.

The Dutch parents talked about their children's sexualities with ease and there was no reference to the anxiety and tension that the English parents conveyed. The English parents were fraught with concerns and their anxiety frequently stymied their attempts at open sexuality communication with their children. For the Dutch parents, whilst several explained that this was not always an easy conversation for them, such anxiety was not a feature of their dialogue. In addition, the English parents' discussions frequently focussed on risk whereas the Dutch approach was positive, as one of the fathers said: *'… first you have human interaction and then you have the human body before you have the diseases. I think the natural course is the way it should be, because interaction with people is much more important than the actual sex part'*.

Another difference appeared to relate to gendered divisions of labour with regards to this aspect of parenting. The English data suggested that these types of conversations were largely the jurisdiction of mothers, but the Dutch data suggested that whilst there was an

expectation that fathers may take the lead more with their sons and vice versa and the mothers generally spent more time with the children which led to greater dialogue, both the mothers and fathers were actively involved and proactive in sexuality related conversations. Indeed, in one case the father was taking the lead in teaching his daughters about sexuality as his wife struggled to do so.

The Dutch parents adopted a gradual, informal approach to sexuality communication which was largely unplanned and spontaneous but deliberately repetitious. For the majority it was just part of everyday life, as one mother said *'we don't make appointments about it'*. In contrast, the majority of the English parents either avoided the subject or adopted a more formal approach with several referring to 'the talk' which was a single isolated discussion which addressed coitus and menstruation for girls but little beyond this. The use of books was also very different with the Dutch parents using these as a catalyst for discussion and as a support for themselves, whereas the English parents had fewer books from which to choose and they tended to hand these over to their children at around age ten to read alone. As one of the Dutch mothers said: *'I believe in talk, like you give a basic book, there's no explanation, it's only words and I would rather explain what these words mean or these feelings that come with sexuality'*.

In contrast to the English cohort, the Dutch parents all asserted that sex education posed no threat to childhood innocence and they could not understand why parents in England may hold this belief (Bennett et al. 2017b). As one mother said: *'I can't really relate to that. I've got difficulty understanding it. I understand but I don't really understand. I don't share it. … No, I don't share. I think that's about meaning. You confuse what sex means to you, to what explaining about where babies come from means to a child. A child doesn't get horny … yes, when I explain to a five-year-old what mummies and daddies do to make a baby, they don't' get horny. It's like something technical. Some simply say, "Yikes!"'.*

It would appear that many of these differences can be attributed to differences between the respective nations in relation to the sociohistorical context of sex and relationships education. In the UK progress has been slow and continues to be (Sheldon 2018, Bennett in press), whereas Dutch attitudes have been much more progressive as outlined in these two videos. However, given that the grandparents of the parents that participated in this study had similar experiences to the English parents in relation to their socialisation regarding sexuality

communication, this study demonstrates that with a structured, cohesive support system change is absolutely possible.

Conclusion and Recommendations

This project exceeded its aims and objectives both in terms of recruitment to the study and the depth and breadth of the findings. The results highlight the need for support for parents in the UK in discussing sexuality with their children. Both the English parents and Dutch parents perceived that open communication could be protective for their children, but the English parents were frequently stymied by their lack of confidence in achieving the openness that they aspired to. The Dutch parents, in contrast, aligned their beliefs with their attitudes and behaviours.

In relating the relevance of these findings to the UK it is useful to draw from the World Health Organisation's (WHO 2010) Standards for Sexuality Education in Europe which emphasise the need for children and young people to know about sexuality, in terms of both risk and enrichment, so that they can develop a positive and responsible attitude towards it. They argue further that holistic sexuality education enables children and young people to live out

their sexuality and their partnerships in a fulfilling and responsible manner and to protect themselves from possible risks. Beyond the individual benefits, sexuality education also contributes to the development of respectful, open-minded attitudes and helps to build equitable societies.

Furthermore, the United Nations (1989) Convention on the Rights of the Child, Article 8 of the IPPF (2008) Declaration, the WHO (2004) Reproductive Health Strategy and the World Association for Sexual Health (2014) emphasise that access to sexuality education is a human right. The findings of this study suggest that the Dutch approach to sexuality education upholds this aspect of human rights, however, in the UK the amount and quality of education that children receive is highly variable. As one Dutch father said: *'If we don't give it any thought or do anything about it, it is like pushing your children through a black hole and just hoping for the best. You have to ask, "how is that taking responsibility for each other?" I think we are obliged to give it thought and help them become healthy young women and men'.*

The recommendations following this Fellowship are, therefore, as follows:

- Sexology and Health Science Honours Degrees and Masters programmes should be developed as specialist subjects in UK Higher Education Institutions (HEIs).

There needs to be investment in the development of Sexology and Health Science education as specialist subjects in UK Higher Education Institutions (HEIs) to enable the development of career pathways and evidence-based practice in sexual health promotion. The Netherlands and Belgium already employ a model which could be replicated in the UK through partnership between HEIs and commissioning bodies for sexual health promotion.

- The commissioning of sexual health promotion services should be orchestrated at the national level.

The current fragmentation of sexual health services has led to inequalities in the provision of sexual health promotion. By commissioning at a national level a cohesive message regarding the value of parent-child sexuality communication can be ensured, along with uniformity of access to services. The Dutch model, in the form of Rutgers, has been evidenced as effective in this regard and should be replicated in the UK through a combination of state and private funding.

- Schools based sex education should be underpinned by an evidence base.

Supportive curricula, such as those designed by Rutgers which are underpinned by research and evaluation, should be made available to teachers. Teachers should also be trained by sexual health promotion specialists so that they are confident and motivated in delivering this aspect of the curriculum.

- Schools should work in partnership with parents to support them in developing their skills in parent-child sexuality communication.

The amendment to the Children and Social Work Act requiring all secondary schools to provide "relationships and sex education" and all primary schools to give "age appropriate relationship education" should include an emphasis on a collaborative approach between the school and the family in imparting relationships and sexuality education. The models adopted by Driestar educatief and Rutgers whereby sexual health promotion specialists hold workshops for parents as part of the respective school-based sexual health promotion programme should be implemented.

- Early parent-child sexuality communication should be promoted.

The UK government and third sector organisations should highlight that early parent-child sexuality communication is protective. This could be achieved through social media campaigns, search engine optimisation for relationships and sex education websites and articles in the national press and magazines.

The experiences of the Dutch suggest that if these recommendations are acted upon, within the next generation we should start to see a positive change in young people's sexual practices and, subsequently, their sexual well-being which will be demonstrable through unintended teenage pregnancy rates and rates of STI amongst young people.

The next steps towards implementing these recommendations concern a knowledge mobilisation plan for the next two years which is as follows:

- Provide press releases.
- Disseminate project report.
- Share findings with UK parents via social media.
- Present findings to UK parenting and children's charities.

- Present findings to UK professional networks.
- Write articles for parenting, nursing and academic journals.
- Disseminate findings amongst UK commissioners.
- Develop a website for parents to use as a resource and to share experiences.
- Develop a short resource book for parents to support them in this role.

References

Association for Young People's Health (2016) A public health approach to promoting young people's resilience. AYPH, London.

Bennett C (2016) Talking to Ten Year Olds about Puberty, Relationships and Reproduction: An Interpretative Phenomenological Analysis of Fathers' Perceptions and Practices. Doctoral Thesis, Cardiff University.

Bennett C, Harden J, Anstey S (2017a) Fathers as sexuality educators: aspirations and realities. An Interpretative Phenomenological Analysis. Sex Education. Available via Gold Open Access: http://www.tandfonline.com/doi/full/10.1080/14681811.2017.1390449

Bennett C, Harden J, Anstey S (2017b) The Silencing Effects of the Childhood Innocence Ideal: The Perceptions and Practices of Fathers in Educating their Children about Sexuality. Sociology of Health and Illness. doi:10.1111/1467-9566.12591

Bennett C, Harden J (in press) Using IPA and a Foucauldian Lens to Explore Fathers' Practices in Talking to their Children about Puberty, Relationships and Reproduction. *Journal of Research in Nursing.*

Campero L, Walker D, Atienzo E E and Gutierrez J P (2011) A quasi-experimental evaluation of parents as sexual health educators resulting in delayed sexual initiation and increased access to condoms. *Journal of Adolescence* 34 (2) 215-223.

CDC (Centers for Disease Control and Prevention) 2016. *Sexually Transmitted Disease Surveillance 2015.* Atlanta: U.S. Department of Health and Human Services. Department For Education (2012) *Under-18 and Under-16 Conception Statistics.* http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy/a0064898/under-18-and-under-16-conception-statistics

Department of Health (2004) *Teenage Pregnancy Research Programme Research Briefing. Long-term Consequences of Teenage Births for Parents and their Children.* http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy/a0066273/teenage-pregnancy-research

Department of Health (2013) A Framework for Sexual Health Improvement in England. London: Department of Health.

FPA (2016) Sexually Transmitted Infections Factsheet. Available at: https://www.fpa.org.uk/factsheets/sexually-transmitted-infections

FPA 2016a UK has highest teenage birth rates in Western Europe. Available at: https://www.fpa.org.uk/news/uk-has-highest-teenage-birth-rates-western-europe

Flores D and Barroso J (2017) 21st Century Parent–Child Sex Communication in the United States: A Process Review. *The Journal of Sex Research* 54 (4–5): 1–17.

Health Protection Agency (2009) *Selected STI Diagnoses and Diagnosis Rates from GUM Clinics in the UK: 2004-2008.* London: HPA.

Health Protection Agency (2012) *Young Adults.* http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1202115502900

Huebner A and Howell L (2003) Examining the relationship between adolescent sexual risk-taking and perceptions of monitoring, communication and parenting styles. *Journal of Adolescent Health* 33 (2) 71-78.

IPPF (2008) Sexual rights: an IPPF declaration. Available at: https://www.ippf.org/resource/sexual-rights-ippf-declaration

Kosunen E A, Vikat A, Gissler M and Rimpela M K (2002) Teenage pregnancies and abortions in Finland in the 1990s. *Scandinavian Journal of Public Health* 30 (4) 300-305.

Lazarus J V, Sihvonen-Riemenschneider H, Laukamm-Josten U, Wong F and Liljestrand J (2010) Systematic review of interventions to prevent the spread of sexually transmitted infections, including HIV, among young people in Europe. *Croatian Medical Journal* 51 (1) 74-84.

Lehr S, Dilorio C, Dudley W and Lipana J (2000) The relationships between parent-adolescent communication and safer sex behaviors in college students. *Journal of Family Nursing* 6 (2) 180-196.

Lewis J and Knijn T (2001). A Comparison of English and Dutch Sex Education in the Classroom The English continue to focus on prevention. *Education and Health*. 19(4): 59–64.

Lucas S (2013) *Unprotected Nation: The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services.* http://www.wecantgobackwards.org.uk/uploads/media/17/15738.pdf

Melville J, Sniffen S, Crosby R, Salazar L, Whittington W, Dithmer-Schreck D, DiClemente R and Wald A (2003) Psychosocial impact of serological diagnosis of herpes simplex virus type 2: a qualitative assessment. *Sexually Transmitted Infections* 79 (4) 280-285.

Mercer CH, Tanton C, Prah P, Erens B, Sonnenberg P, Clifton S, Macdowall W, Lewis R, Field N, Datta J, Copas AJ, Phelps A, Wellings K, Johnson AM (2013) Changes in sexual attitudes and lifestyles through the lifecourse and trends over time: Findings from the British National Surveys of Sexual Attitudes and Lifestyles (Natsal). *Lancet*. 2013; 382: 1781-1794. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2962035-8/fulltext

Miller B, Benson B and Galbraith K (2001) Family relationships and adolescent pregnancy risk: A research synthesis. *Developmental Review* 21 (1) 1-38.

Nack A (2008) *Damaged goods? Women living with incurable sexually transmitted diseases.* Philadelphia: Temple University Press.

Nagamatsu M, Saito H and Sato T (2008) Factors associated with gender differences in parent-adolescent relationships that delay first intercourse in Japan. *Journal of School Health* 78 (11) 601-606.

Office for National Statistics (2014) International comparisons of teenage births. Available at: http://webarchive.nationalarchives.gov.uk/20160105202748/http://www.ons.gov.uk/ons/rel/vsob1/births-by-area-of-usual-residence-of-mother--england-and-wales/2012/sty-international-comparisons-of-teenage-pregnancy.html

Office for National Statistics (2017) Conceptions in England and Wales: 2016. Available at: file:///C:/Users/benc1/Downloads/Conceptions%20in%20England%20and%20Wales%202015.pdf

Ogle S, Glasier A and Riley S (2008) Communication between parents and their children about sexual health. *Contraception* 77 (4) 283-288.

Public Health England (2017) Sexually Transmitted Infections and Chlamydia Screening in England, 2016. Health Protection Report. 11 (20): 9 June 2017

Public Health Wales (2017) HIV and STI trends in Wales. Communicable Disease Surveillance Centre. June 2017.

Royer H R and Cerf C (2009) Young women's beliefs about the terms sexually transmitted disease and sexually transmitted infection. *Journal of Obstetric, Gynecologic & Neonatal Nursing* 38 (6) 686-692.

Rutgers and Soa Aids (2017) Sex Under the Age of 25. Lifestyle Monitor (Sex Under 25/Lifestyle Monitor), Rutgers/Soa Aids of the Netherlands in partnership with the Dutch National Institute for Public Health and the Environment (RIVM).

Sedgh G, Finer LB, Bankole A, Eilers MA, Singh S (2015) Adolescent pregnancy, birth, and abortion rates across countries: levels and recent trends. *Journal of Adolescent Health* 56: 223-30.

Sheldon, T (2018) Could Dutch style sex education reduce pregnancies among UK teenagers? *British Medical Journal* 360 (j5930) doi: 10.1136/bmj.j5930

Shepherd J, Kavanagh J, Picot J, Cooper K, Harden A, Barnett-Page E, Jones J, Clegg A, Hartwell D, Frampton G K and Price A (2010) The effectiveness and cost-effectiveness of behavioural interventions for the prevention of sexually transmitted infections in young people aged 13-19: a systematic review and economic evaluation. *Health Technology Assessment* 14 (7) 1-206, iii-iv.

Ricoeur P (1970) Freud and Philosophy: An Essay on Interpretation. New Haven: Yale University Press.

Smith J A (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology.* 1 (1) 39-54.

Smith JA, Flowers P and Larkin M (2009) *Interpretative Phenomenological Analysis. Theory, Method and Research.* London: SAGE.

Smith JA and Eatough V (2012) Interpretive Phenomenological Analysis. In: *Research Methods in Psychology, Fourth Edition,* edited by G.M. Breakwell, J.A. Smith and D.B. Wright, 440-459. London: SAGE.

Somers C and Paulson S (2000) Students' perceptions of parent-adolescent closeness and communication about sexuality: relations with sexual knowledge, attitudes and behaviors. *Journal of Adolescence* 23 (5) 629-644.

Spinelli E (2002) The Mirror and the Hammer: Challenging Orthodoxies in Therapeutic Thought. London: Sage.

Stone N, Ingham R and Gibbins K (2013) "Where do babies come from?" Barriers to early sexuality communication between parents and young children. *Sex Education*. 13 (2) 228-240.

Stone N, Bengry-Howell A, Ingham R and McGinn L (2015a) *Early Sexual Socialisation and Sexuality Education: Parental Perspectives. "How Should We Tell The Children?".* Southampton: University of Southampton.

Stone N, Ingham R, McGinn L and Bengry-Howell A (2015b) *Talking to Young Children About Relationships, Babies and Bodies: What Parents Think.* Southampton: University of Southampton.

United Nations (1989). Convention on the Rights of the Child. New York.

UNICEF (2001) *A League Table of Teenage Births in Rich Nations. Innocenti Report Card 3.* Florence: UNICEF.

UNICEF (2007) *Child Poverty in Perspective: An Overview of Child Wellbeing in Rich Countries. Innocenti Report Card 7*. Florence, Italy: UNICEF.

UNICEF (2012) *Children in an Urban World. The State of the World's Children 2012.* http://www.unicef.org/sowc2012/fullreport.php

Widman L, Welsh D, McNulty J and Little K (2006) Sexual communication and contraceptive use in adolescent dating couples. *Journal of Adolescent Health* 39 (6) 893-899.

Widman L, Choukas-Bradley S, Noar SM, Nesi J and Garrett K. (2016) Parent-Adolescent Sexual Communication and Adolescent Safer Sex Behavior: A Meta-Analysis. *JAMA Pediatrics* 170 (1) 52–61.

WHO (2004). Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Global strategy adopted by the 57th World Health Assembly. Geneva. Available at: http://whqlibdoc.who.int/hq/2004/WHO_RHR_04.8.pdf

WHO (2010) Standards for Sexuality Education in Europe. Available at: file:///C:/Users/benc1/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/YQ4IMFMY/WHO_BZgA_Standards.pdf

WHO (2012) *Social Determinants of Health and Well-being Among Young People. Health Behaviour in School-Aged Children (HBSC) Study: International Report from the 2009/2010 Survey.* Copenhagen: WHO Regional Office for Europe.

World Association for Sexual Health (2014) Declaration of Sexual Rights. http://www.worldsexology.org/wp-content/uploads/2013/08/declaration_of_sexual_rights_sep03_2014.pdf