IPPF

From choice, a world of possibilities

Over-protected and under-served

A multi-country study on legal barriers to young people's access to sexual and reproductive health services

United Kingdom case study

coram clc
Children's Legal Centre

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations.

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Glossary

GP	General Practitioner (Medical doctor)
GUM Clinic	Sexual Health or Genitourinary Medicine Clinic
HIV	Human Immunodeficiency Virus infection
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
NHS	National Health Service
PSHE	Personal, Social and Health Education
SRE/RSE	Sex and Relationships Education / Relationships and Sexuality Education
SRH	Sexual and Reproductive Health
STI/STD	Sexually Transmitted Infection / Sexually Transmitted Disease
YP	Young Person

1 Introduction

In 2012 the International Planned Parenthood Federation (IPPF) commissioned a pilot multi-country research project exploring legal barriers to young people's access to sexual and reproductive health (SRH) services. The study was designed and implemented by Coram Children's Legal Centre. It comprised two stages: a global mapping of laws related to young people's access to SRH services from around the world; and qualitative field research which took place in three jurisdictions: El Salvador, Senegal and the UK.

The case study countries were selected to represent different legal systems, and contrasting social, cultural, religious and political traditions. The case studies examined the operation of legal barriers to SRH services from the perspectives of young people and service providers; seeking to understand how both law, and knowledge and perceptions of law, intersect with other factors in different contexts to influence young people's experiences accessing a range of services.

This report contains an analysis of the research carried out in the United Kingdom. Analyses of the research carried out in El Salvador and Senegal are available as separate publications.

1.1 Rationale for the research

While there is an extensive body of literature which explores social, cultural and economic barriers to young people's access to SRH services in a range of contexts around the world, much less is known about the role of law in influencing and shaping access to SRH. This is despite the fact that every state around the world, without exception, has developed legislation that is in some manner designed to purposefully regulate and restrict access to SRH for different groups of people, in different circumstances.

In recent years there has been a growing interest among SRH advocates and activists in exploring the interplay between legal frameworks and access to SRH services.[1] This exploratory research project contributes to efforts to build evidence and knowledge in this area, to guide future advocacy and programming work, with the ultimate aim of fulfilling young people's rights to sexual and reproductive health.

1.2 Methodology

The overall aim of the research was to assess the extent to which the law, as well as young people's and service providers' knowledge and perceptions of law, impact upon young people's access to sexual and reproductive health services.

The methodology and tools were designed to answer the following questions:

- What are the direct and indirect legal barriers that impact on young people's access to SRH services?
- How do different legal principles and provisions facilitate or inhibit access to SRH services for young people both directly and indirectly?
- What do young people know about the law as it applies to SRH services?
- What do they know about the law as it applies to sexuality and sexual activity?
- How do young people perceive or interpret such laws as applying to themselves or their peers?
- How does this knowledge and perception impact on their access to SRH services?
- What are their experiences accessing SRH services and information? How do they expect this process to occur?
- What are the gaps in their information and access?
- How do legal barriers interact with social, cultural or other barriers to accessing SRH services?

1.2.1 Country selection

The United Kingdom was included as a case study to provide an example of a relatively non-restrictive or 'facilitative' environment for young people's access to SRH services; the law provides few explicit, direct barriers to young people's access to a full range of sexual and reproductive health services, with the exception of the restrictive legal framework concerning access to abortion in Northern Ireland. However, the law in the UK nonetheless creates both direct and indirect barriers to young people's access to sexual and reproductive health services. This study explores the impact of both types of legal barriers on young people's access to SRH services. It also considers the role and impact of laws in helping to facilitate improved access to SRH services.

1.2.2 Sampling

Research for this case study was carried out at a variety of sites in three locations across England and Wales: in and around greater London; Manchester; and Cardiff; and in three locations in Northern Ireland: Belfast, Lisburn and Derry. Research at these locations involved a series of focus group discussions and individual semi-structured interviews with young people, and semi-structured interviews with sexual health service providers.

Young people were generally selected through youth service providers (sexual health providers, and general youth services) and schools / colleges. The research included 'general' groups of young people as well as particular groups of young people likely to be impacted by laws and access to sexual health services in a specific way, or who have a particular need for services arising from their identity or circumstances. These groups were identified by researchers based on findings from the literature review. Service providers were also selected on this basis. Specific groups included: LGBTI young people; young mothers; young people from deprived backgrounds; young people who have experienced family breakdown and / or homelessness; and survivors of sexual violence. Researchers carried out 19 focus group discussions; 15 individual interviews with young people; and 12 individual interviews with service providers.

1.2.3 Research methods

Individual interviews

Given the sensitive nature of the research, and the fact that it involved speaking to young people about their behaviour, choices, perceptions and experiences related to accessing sexual health services, it was important to conduct a number individual interviews in private settings to allow for the fullest possible responses to the research questions. Interviews were qualitative and semi-structured in nature. Data collection tools were developed to facilitate a level of standardisation in the data collected. The tools were used as guides to allow the interview to be steered by the respondent, within the broader frame of the research questions.

Interviews included a mix of life history questions and questions that focused on perceptions of law and access to SRH services, in order to explore how participants' social environments and lived experiences have shaped both their understandings of law, and experiences relating to accessing services. This facilitated understanding of whether the legal environment affects young people's seeking of, and access to, SRH services differently depending on other social and environmental factors, and to determine how other factors that influence access and service seeking behaviour interact with the legal environment. Following a 'life history' structure through interviews also allowed researchers to access information about how (and why) perceptions of law and access to SRH services might change over time.

Focus groups

Focus group discussions (FGDs) were conducted with both service providers and young people. FGDs consisted of groups of up to 13 individuals. Data collection tools for focus group discussions were designed to encourage respondents to discuss issues in a general, hypothetical, or scenario-based format, so that they did not feel the need to reveal information about personal experiences. FGDs provided a useful opportunity to investigate the contexts and situations that might impact on young people's access to SRH services. Respondents were presented with a series of 'scenarios' and asked to discuss/debate how they viewed the situation, as well as their perceptions of how the law applied to the situation. Exploring these issues through an FGD enabled participants to respond to each other's ideas and opinions, stimulating discussion and debate. FGDs are generally more interesting for participants than individual interviews, and provided for a fun and relaxed environment for exploring the research questions. It was necessary for researchers to consider the implications of social pressure and other group dynamics, when analysing group responses.

1.2.4 Ethical guidelines

Due to the sensitivity of the research topic, which dealt with issues of sexual behaviour and (at times) violence, along with the young age of the participants, special care was taken to ensure that the research did not cause harm to the participants and that ethical guidelines were set out and strictly followed. All researchers involved in the project were experienced in carrying out research with children and young people, particularly vulnerable children.

1.3 Understanding the relationship between law and access

Direct legal barriers are laws that explicitly apply (age-related) restrictions on access to SRH services, and include, for example, laws restricting a young person's access to types of contraception or abortion either absolutely, or where they are below a specified age; or laws that require a young person to obtain the consent of their parents before accessing SRH treatments. Direct laws also include laws that limit a service provider's obligations to provide confidential access to services in particular situations, for instance where it is assessed that the child is at risk. Such laws rely on professional judgement and may be interpreted in line with professionals' own expectations or social or cultural beliefs. For example, a law permitting or requiring a service provider to breach their duty of confidentiality where they suspect a child is at risk or harm may be applied by a service provider where a child is found to have engaged in sexual activity below a particular age, even where there is an absence of exploitation involved in the sexual activity.

Indirect legal barriers are laws that do not directly restrict access to SRH services, but nonetheless may function in this way. For example, laws specifying an age of sexual consent below which it is unlawful for a person to engage in sexual activity may have the effect of restricting access to SRH services, as a young person may fear being criminalized for having sex with a person

below the age of consent where they access services in relation to this activity. Lack of legal recognition of particular sexualities or gender identities can also operate as an indirect legal barrier. This can have the effect, for example, of facilitating service provision around gender-binary identities, thereby marginalising third gender, intersex or genderqueer young people.

Laws do not only function as barriers to accessing SRH services. They can also create a framework through which young people are **empowered to make informed decisions** around sexual health matters, and safeguard their own sexual health, or **facilitate easier access to SRH services**. Laws providing for compulsory, comprehensive sex and relationships education in school are an example of a legal framework that can empower young people to access services and make healthy and informed decisions about their sexual health. Confidentiality duties imposed on service providers is also an example of a 'facilitative' law.

2 Young people, sexuality and the law in the UK

2.1 Social, cultural and economic norms impacting on a young person's access to SRH services

Legal barriers to young people accessing SRH services should be considered together with the range of social, cultural and economic factors that shape sexual behaviour in the UK. Young people's ideas around sexuality in the UK were found to be shaped by cultural, social and religious norms, and the research identified several norms that appear to be operating as significant barriers to young people accessing SRH services.

2.1.1 Stigma and embarrassment relating to sex among young people

Many research participants mentioned stigma relating to sex among young people as creating a barrier to young people accessing SRH services. Participants commonly referred to restrictive social norms around young people engaging in sexual activity: *"I think it's because there is a lot of stigma attached to sex and younger age sex so I think people judge you for that"*.[3] Young people experienced pressure from adults to abstain from sex, causing them to feel ashamed about being sexually active and about enjoying sex.

At the same time, growing exposure of young people to sexualised and sexually explicit content in media (internet, TV, magazines), appears to be sending the mixed message that, while sex for young people is still a taboo topic within society, young people themselves are being encouraged to engage in sexual activity at a younger age. One girl in Northern Ireland stated that they are *"slagged for being a virgin"*[4] by young generations, and simultaneously told to wait until they are married by older generations. Therefore, while young people are clearly engaging in sexual activity, and are in many ways being encouraged do so by peers and by modern culture, they are simultaneously being stigmatized as a result of dominant social and cultural norms. This has significant implications for their ability to, and the likelihood of, accessing the SRH services they need freely and without embarrassment or shame.

Restrictive norms regarding sex among young people appeared to be particularly significant in **Northern Ireland**. The ideas of young people in Northern Ireland are framed by cultural and religious norms that strongly promote abstinence among young people. While participants discussed the Northern Irish population in terms of being "two communities", both communities appear united in their disapproval of young people's sexuality.

> We live in a society that has two very distinct communities, and sex before marriage is not seen to be an acceptable form of activity.[5]

"I think there are a lot of young people that find it very embarrassing to use sexual health services. I sure am!"[2]

> The communities that we live in tend to be quite religious and it would not be expected that you would have sex before marriage, and it would not be expected that you would be having sex at a young age, so it would be family and society morals which would have an effect on that as well.[6]

It is felt that attitudes are slowly changing and have become more permissive in recent years; however, sex among young people is still largely frowned upon, and sexual activity undertaken outside of a long–term relationship or marriage is often construed negatively in Northern Ireland. The importance of being in a long term relationship before engaging in sexual activity appears to be heavily emphasised to young people in Northern Ireland, especially young women, who are aware that they will be seen as promiscuous for engaging in any sexual activity outside of a relationship, and would be stigmatized and blamed for any consequences such as sexual health problems or teen pregnancy. Young people's views in Northern Ireland appeared to be heavily influenced by the faith-based messaging they received at home, in schools and within their wider community.

Social norms restricting open and frank discussion about sex across the UK appear to reinforce the idea that sex is a 'taboo' subject, and something that young people should feel ashamed of.

> I would say socially the British way of not talking about sex, this is something we're all very aware of. I think most commonly when we're talking [to young people] about, "have you spoken to your parents about the fact that you're having sex, do they know you're sexually active?", the response is usually, "oh no, we wouldn't talk about that".[7]

Norms restricting young people from talking about sex with parents and other adults reinforce a sense of stigma or shame attached to sex. It also appears that lack of sex and relationships education in some schools or the provision of education that is confined to very limited biological aspects of reproduction and prevention of STIs in the UK means that young people lack the language in which to speak openly about sex, relationships and sexual health: *"Because there is no education, it's been a blocked off subject and when it is delivered it's usually delivered badly so you almost feel awkward for talking about it, let alone going to get contraception"*.[8] This reinforces the idea that sex is a 'taboo'

subject, and restricts the ability for young people to speak openly and honestly about sex.

Perhaps as a result of these restrictive norms, many young people involved in the study expressed a sense of embarrassment or shame at the thought of, or through a personal experience of, accessing SRH services, and young people tended to see this as creating an indirect barrier to accessing these services.

> **If you think some people are not using condoms, why not?**
>
> Embarrassment having to go in shop and buy condoms… I know lots of people who wouldn't.
>
> I go in for my friends.
>
> I got stared at by the person behind the till.
>
> There are a lot of people our age who wouldn't.[9]

Young people reported that they would feel embarrassed explaining a sexual health need or problem to a professional, in particular a doctor, who young people tended to view as being more formal and judgemental: *"I think people will worry about that [going to a GP], that they will judge you, tell you off, they'll worry and they'll tell your parents"*.[10] Some service providers thought young people's embarrassment was negatively affecting their confidence in accessing services, perceiving it to be a barrier: *"Walking into a sexual health service is very daunting. Asking a receptionist, when there are 20 people behind you, 'can I see a doctor please?' at 16, or at 13 years, can be quite daunting"*.[11]

In Northern Ireland, young people and service providers made frequent links between embarrassment and shame, brought on by the normative value placed on abstinence and the stigma attached to young people's sexuality. Many young people cited experiences or fears of being judged by service providers for engaging in sexual activity due to their young age, being outside of marriage or a long term relationship, or identifying as LGBTI. Social, cultural, and religious norms appeared to play a lead role in constructing these impressions.

The location and configuration of SRH services is significant, and can reinforce the sense of embarrassment felt by young people in the UK. General health services, such as GP clinics or surgeries, are not "set up" for young people seeking confidential advice or treatment relating to sexual health.

> I go to the [GP] clinic window and I say, "Can I make an appointment with the nurse please?" It's about contraception, but there's loads of people behind me. She says, "What's it about?" I was like, "I'll discuss that with my doctor. I don't have to explain anything to you." And she said, "But I need to put something down", and she actually made me go around the back and tell her. I'm like, "Are you fucking serious?"[12]

Young people generally felt more comfortable accessing services through specialist youth sexual health service providers. The reason for this is that these specialist providers were perceived as being confidential, more relaxed and supportive: *"people don't go to the doctors for things like that (contraceptives), but go to Brook and can have a laugh. They're young people and it's more difficult going to a GP, especially for girls if the doctors are males. Brook is more confidential and supportive. I don't think GPs are very supportive"*.[13]

Young people also expressed concern at "bumping into" people they know at locations in which they access SRH services, including doctor's surgeries, specialist SRH service providers, and also in chemists or shops, while buying contraceptives or pregnancy tests, for example.

> Some people find that hard though, embarrassing, some people find it mortifying.
>
> **Why would they be embarrassed?**
>
> If someone sees them, a family member, 'cos you never know who's round the corner.[14]

This barrier appears to be particularly significant in rural locations, in which there is a perception that "everyone knows you". In these locations, it also appears that there is lack of provision of specialised SRH services for young people.

> I come from the very, very north of England; basically that green bit between England and Scotland. When I was between 11 and 15, you heard about girls getting pregnant and leaving school to be teenage mums and it was awful. But for us, we had like one Boots and all the people who worked there, you knew them, or you knew people who knew them or you went to school with their children, so there was no way. I mean I had to go in and actually buy stuff for my friends as they were just too embarrassed. I mean, within a week I bought condoms and pregnancy tests. None of them were for me, but they must have been like: "what is she doing?" Just because some of my friends were so embarrassed and it was this sense of "you should not be having sex" and if you are it's because you are a slut or you're dirty, very much on the girl's side.[15]

Young people appear to be more heavily impacted by a sense of shame or embarrassment at "bumping into people" where they live in more closed communities in which there may be more restrictive norms applying to young people and sexuality.

> My friend lives around Edgware Road and even right in the centre of London there are communities within communities. So she's Muslim, she's Iranian, so while she knew other people, all the Iranians knew each other and stuff, so she would even get into Boots or a Superdrug to get certain things, and there was always this risk of bumping into someone. So I think there is that risk that also exists within small communities in large cities.[16]

Some young people also reported that they faced barriers in accessing SRH services as service providers imposed their own behavioural expectations on them, limiting their access to SRH services. Some young people expressed having felt judged and "looked down on" by a service provider, when they had accessed an SRH service.

> I actually went in once and screamed at the doctor's face for a little because my friend had gone in and she was about 17. She wanted to get tested for something because she wasn't sure, and the doctor just raised both eyebrows and went "well, do you know you're going to hell?" and she came out sobbing and I was like "wait here"… it's harder when you are at that age, because the services… it's a person with opinions, rightly or wrongly, and pre-assumptions and things like that.[17]

In Northern Ireland, this was constructed in terms of a barrier to access whereby young people thought they could not, for example, discuss abortion with a doctor.

Embarrassment and shame is a barrier that is compounded by other factors. It appears to impact on young people with particular identity characteristics or from particular backgrounds more significantly. Girls may feel a greater sense of shame or embarrassment in disclosing that they were involved in sexual activity, and in discussing the details of this activity with a service provider. Some young people reported that they would not disclose non hetero-normative identity to their doctor for fear of being judged.

2.1.2 Gender norms and expectations of sexual behaviour

Many young people across all research locations indicated that there are different social standards and expectations relating to sexuality according to gender. Gender norms appear to relegate girls to a position of being guardians of sexual morality, and impose more restrictive norms on their engagement with sexual activity, while holding them more responsible for unintended consequences of sex, such as pregnancy. Young people perceived that it is honourable and good for the reputation of boys to be seen to be having sex. Teenage girls, on the other hand, tend to receive mixed messages about sex, placing them in a situation in which they are encouraged to be sexually available, yet are judged or looked down on for being sexually active: "*There is great pressure being placed on girls to be sexually active, but if they are, they're slated terribly by their peers and by boys, so they're in a 'can't-win' situation*".[19]

"As a boy, when they go in there [to a sexual health service provider], they'll be proud. If someone sees them, they'll be pleased people will see them and think they're doing more things than others. But girls don't want to be seen. People might think they're bad. Girls are less likely to use services because of that".[18]

For girls, having sex appears to damage their reputation and can lead to them being subjected to social ridicule and bullying.

> I don't think boys get bad reps…and they don't give a fuck; if a girl sleeps with 20 guys, she's a sket. If a guy sleeps with 20 girls, he gets a good rep.[20]

> If girls sleep around or give blow jobs, they get a bad reputation. One girl at our school gave a boy a blowjob and every time she walks past people, they say 'brainer'. For a boy, he gets a good reputation and respect.[21]

> Nowadays, you get most girls going round having people under age. They make a name for themselves. Some boys do the same thing, but they don't get the names and things, but girls get called hos, sluts, skets.[22]

> If a girl sleeps with loads of guys, she's a complete and utter whore, but a guy can sleep with as many girls as he wants and he'll get a pat on the back for it.[23]

> It's always gonna be more acceptable for a boy to be a slag than a girl.[24]

Girls who are sexually active tend to be seen as lacking in self-esteem and self-respect and as being promiscuous; the same does not apply to boys: "*Most girls, they go round and round and round with different people. They should have more respect for themselves. People will think they're easy and boys won't respect them*".[25]

These norms may be creating a barrier to girls accessing SRH services, causing them to feel a greater sense of shame or embarrassment in disclosing to a professional that they have engaged in sexual activity.

> **Would you tell a doctor (about a sexual health problem)?**
>
> Yeah, it'd be alright going to a doctor; it wouldn't be difficult.
>
> **Would it be embarrassing?**
>
> Yeah, it would be embarrassing.
>
> **Would it be different depending on whether you're a boy or a girl?**
>
> Yeah, girls have an image to uphold.
>
> **Why would girls be more nervous about people knowing they had sex?**
>
> They have a rep to uphold; people might call her a slag.[26]

Some groups of young people are impacted by particularly restrictive gender norms around sexual behaviour. One service provider mentioned young people from Traveller communities as facing additional barriers to accessing SRH services, arising out of social expectations restricting sexual activity outside of marriage and pressures relating to childbearing within marriage: "*Women (from Traveller communities) are not meant to have sex before marriage. After marriage, they are meant to be having children*".[27] This restricts their access to particular SRH services, including contraception and STI testing, for instance.

2.1.3 Hetero-normativity of SRH services

Mainstream SRH services were perceived by many LGBTI young people who participated in the study as being hetero-normative, and gender-binary. This can operate as a barrier by making LGBTI young people feel excluded from the service. Professionals in mainstream services were perceived by many LGBTI young people as lacking awareness about issues that relate to lesbian, gay and bisexual young people, and in particular, to issues relating to transgender, third gender, genderqueer and intersex young people.

> Some people don't know what third gender is and I think that it can have a lot of implications when it comes to sexual practices and identifying body parts and getting STI tests and being referred to with the correct pronoun and things like that.[29]

This can also be a barrier to full disclosure by young people who access SRH service providers, which can impair the ability of young people to access appropriate, quality services.

> You think that, what if maybe I do get a raised eyebrow, maybe I should not mention that partner because it's easier. Mostly, I think, most of the services I have access to are really good, no one has been judgemental about anything that's unusual. But I imagine that, for someone knowing that your lifestyle is unusual, you just don't want to bring it up sometimes, because it's just easier.[30]

> "Doctors who aren't comfortable dealing with gay men; this is obvious to a young person. They're not going to come back or feel comfortable or confident accessing the service".[28]

Hetero-normativity of mainstream service provision can also be a barrier to the type and quality of services young people are able to access, in particular, in relation to services that are specifically needed by LGBTI young people (particular types of contraception used in same-sex sexual activity or advice that would apply to young persons who are undergoing hormone therapy, for instance): "*I had problems with my GP. He didn't know what the hell to do. I waited three and a half years for a referral, so then I decided to go privately*".[31] This finding supports an earlier finding from the LGBTQ Sexual Health Services Survey, in which more than a quarter of respondents reported that staff in SRH services could not offer the right help because of their gender identity, and a third reported that staff could not offer the right help because of their sexual orientation.[32]

According to some service providers, the lack of understanding and awareness of LGBTI issues also exists within specific SRH services. There appears to be a lack of conscious thinking around how to include LGBTI young people in mainstream SRH provision:

> We're doing a lot of work around making services LGBT-friendly in Hillingdon; an outer-London borough. I've gone to meetings and I'm sitting there in the youth space and we're doing a provider's meeting and I ask, "how do you support different groups of young people?", and they say "everyone is welcome here", and I say "well, how do you know?", and they say "everyone's welcome"; "how do you support LGBT young people?"; "they're welcome"; "how would they know that?"; "what do you mean?"; "well, you've got lots of posters on the walls, but not a single one represents anything to do with LGBT young people"… Even where provision is open to all, you need to have specialists for LGBT young people.[33]

Lack of awareness of issues relating to LGBTI young people can lead to erroneous assumptions which impede access to quality, tailored provision for these young people.

> I think sometimes people feel a little like their needs aren't catered for or addressed. We do try to cater for all and be inclusive and be openly supportive but even then, there is still work to be done. There are still assumptions – especially in relation to sexual health, so if a young man identifies as gay, it is assumed that he is definitely having anal sex for example, or that a young woman who has a child is heterosexual. We still make assumptions and judgements on those assumptions and that can be quite telling when it comes to sexual health.[34]

LGBTI young people in Northern Ireland also appear to face increased barriers to accessing services, as young people felt that services and information are often focused on reproduction over other aspects of sexual health. Young LGBTI people felt they were less likely to engage with services or use protection since they were not at risk of pregnancy.

> I think access is difficult: if you go to your family planning, it's called family planning and they think it's not for them. And if you think sexual health and emergency contraception, well I don't need emergency contraception. There's lots of GU [Genito-Urinary (Sexual Health) Services] – in saunas and places like that, which is great, but shouldn't have to go to sauna to access it.[35]

In Northern Ireland, knowledge among service providers of LGBTI issues was reported to be low and provision of specific LGBTI services limited, with lesbian girls feeling that service providers did not understand and often could not provide for their sexual health needs. LGBTI young people in general felt judged by service providers (apart from Brook) and felt that they experienced prejudice from doctors when already feeling particularly vulnerable in accessing a sexual health service. One girl commented that accessing a sexual health service was "*like coming out all over again*".[36]

In rural areas, it was reported that service providers did not tend to see a need for specialist LGBT provision, as there is not a perceived demand for it.[37]

Non-health professionals that young people come into contact with may also lack awareness and sensitivity in LGBTI issues, and this can create a barrier to accessing services. One transgendered young person reported having a very negative experience with police officers when, as a young child, they made a disclosure of sexual abuse. He was made to describe the sexual abuse on him in terms of biologically female body parts, when he identified as male, causing him considerable anguish.

> I had to lay on the tables and that, legs wide open… They needed physical evidence, and my word as an 8 year old wasn't really good enough. It went through the court and they said because there's no physical evidence it wasn't charged. I felt so uncomfortable with my bits of biology. My mother blames that now for why I am a bloke, but I always knew I was a boy. I asked her when I was 5 when I was going to grow a penis.[38]

> "In the urban population in Belfast, it's much easier to access [services], but outside it's much harder: there are limited opening times due to funding issues and, if younger, where are they going to say they're going? Where are they going to get the money for the bus? And there's an added difficulty of coming to a city they've never been to before".[40]

This experience caused the young person to decide not to report a rape that occurred later in his teens to the police: "*that was traumatic enough, and I didn't want to go through all of that [again]*".[39]

While hetero-normativity of services does not appear to be a legal barrier, this barrier can be seen as being at least supported or compounded by indirect legal barriers. Lack of legal recognition of third gender, genderqueer and intersex young people, for instance, can be seen to operate as an indirect legal barrier, as discussed in more detail below. Legal frameworks inform policies and structuring of services in the health sector, and a lack of legal recognition for these young people creates no imperative for mainstream services to make provision for young people who do not identify in a gender-binary way.

2.1.4 Cost and practical barriers

While many SRH services are provided to young people for free in the UK where accessed through a National Health Service (NHS) provider, young people reported that cost, for example of contraceptives or pregnancy tests, could be a barrier where they are reluctant or fearful of visiting a doctor. In this case, they can access contraceptives or pregnancy tests from pharmacies or shops, but may not be able to afford to pay for them. In Northern Ireland, young people felt that the morning after pill was particularly expensive, but thought they might not be able to access it from a service provider due to the distance or limited opening times, and they would not feel comfortable going to their doctor for it, due to concerns around confidentiality and judgement. Cost was also cited as one of the main barriers to accessing abortion, since it could only be obtained outside of the restrictive limits, by travelling to other parts of the UK.

Other practical barriers included the limited opening hours of SRH service providers, and opening hours that did not take into consideration the needs or restrictions of young people; it was reported by some young people that opening hours are restricted to times when young people are in school and weekend closures were also reported to be a problem. Young people reported that SRH providers may be located some distance from their homes. Practical barriers like cost and distance can have a significant impact on young people, who are more reliant on parents or guardians and lack independent means to buy SRH products or to travel to an SRH clinic. This appears to have a more significant impact on young people who live outside town centres, or in rural locations: *"A lot of young people, especially the most vulnerable ones, won't have the money to get into town and access a service"*.[41]

Young people may also be unable to access SRH services if they are concerned about their parents finding out, especially when services are located some distance from them.

> There will be some parents, quite a few parents, wanting to know where young people are and again, the worry of "what are people going to think of me" going to a clinic associated with sex, but it is also, how do we get out there and tell people that we're there?[42]

Young people and service providers in Northern Ireland frequently cited the difficulty of accessing SRH services in rural areas as one of the most significant barriers affecting young people. The low level of provision, or more limited provision than in urban areas, combined with frequently non-integrated SRH services, means that young people have to travel to Belfast or another city or large town to access the services they need.

Even within other cities, services were not often described as easily accessible. In Derry, Northern Ireland's second largest city, young people reported having to walk for an hour to visit the GUM (sexual health) clinic placed slightly outside of the city-centre, and in Lisburn, Northern Ireland's third largest city, many young people thought they would still need to go into Belfast (a 20 minute drive, bus-ride or train journey) for sexual health testing. This increased difficulty and expense creates a barrier for many people, but especially, we were told, for young people who may not have the means to pay for travel, and who would need to find an excuse to tell to parents to explain their absence or need for the trip. This of course affects their ability to access services confidentially, and when taking into account the restrictive normative framework described above, they may feel unwilling to risk their parents finding out and instead choose not to access the SRH service they need at all.

The location of some GUM clinics and other services was also a concern for young people who spoke of instances of waiting in queues in the street or along busy hospital corridors, where they were fearful of being spotted by someone they knew. Opening times were also described as being non-facilitative of access – clashing with usual timings for school and extra-curricular activities.

> "The law isn't the biggest barrier. It's more the ideas around the law; the misconceptions and lack of understanding of the law".[43]

2.2 The significance of legal barriers

According to Government policy, the legal framework for regulating young people's access to SRH services in the UK aims at the creation of an 'honest and open culture' in which persons are empowered to make informed and healthy choices about relationships and sex.[44] Accordingly, the law does not appear, at least deliberately, to impose significant barriers on young people's access to SRH services, with the exception of access to abortion in Northern Ireland.

The research found that laws are not perceived by young people in the UK to be the most significant barriers to their accessing SRH services. When participants were asked general questions about barriers to accessing services, "the law" was never mentioned, and young people rarely mentioned specific laws spontaneously. This indicates that laws are not perceived to be the most significant barriers to accessing SRH services. However, this does not necessarily indicate that laws do not impose significant barriers to young people accessing SRH services, or that young people did not consider the law as imposing barriers "on paper". Many young people involved in the research either did not see the law as applying to their actions, or did not believe the law is or could be enforced.

Also, the fact that young people did not couch concerns about SRH in terms of restrictive laws could be indicative of the relative strength of social, cultural and religious norms, as examined above. While these barriers were not perceived as being prescribed by law, some of the barriers can be seen as being informed by laws and constructed by the absence of legal frameworks (for instance, the sense of embarrassment which appears to operate as a barrier to access is reinforced by a lack of legally prescribed compulsory comprehensive sex and relationships education in schools, as discussed below).

In general, and as illustrated throughout the findings, young people involved in the research in all locations appeared to have a good general level of knowledge of relevant laws. The level of knowledge of laws, however, may be explained as many participants were accessed through SRH service providers or youth

groups, and likely had a higher level of engagement with SRH issues than the majority of young people.

There was a significant difference in the level of knowledge on laws relating to young people who identify as LGBTI; many of those accessed through specific LGBTI youth services were highly aware of the legislative context in the UK regarding SRH and LGBTI rights and services. This could be explained by the quality of the LGBTI youth services through which young people were accessed, as well as their increased need to pursue their own research, due to the absence of information relevant to their sexuality and identity within formal education.

Young people's general understanding of the relevant laws did not, in many cases, extend to knowledge of the implications of laws, nor how they were applied in practice. For example, while young people were mostly aware of the age of sexual consent, a significant proportion were uncertain about whether it would be enforced, and what the implications would be in terms of prosecution. Similarly, in relation to confidentiality and competency laws, young people knew they were entitled to access services prior to reaching the age of sexual consent, and they frequently referred to medical professionals' duty of confidentiality; however, they were consistently uncertain of their rights in this area, conflating law on the age of sexual consent with that of the age of medical consent and confidentiality.

> Do you have to be certain age to access contraception?
>
> **YP1:** If the age [of sexual consent] is 16, it makes sense that that's the age limit on contraception.
>
> **YP2:** It makes sense to give it to 14 yr olds too though, 'cos they will just do it anyway.
>
> Would they need permission from anyone to access contraception?
>
> **YP2:** If younger than 16, probably.[45]

As can be seen throughout the findings, there was an associative relationship between the lack of knowledge of the law and barriers to access. For example, the criminalisation of underage age sexual activity was found to be influencing young people's interpretation of the law relating to confidentiality, as some young people appeared to think the duty of confidentiality would automatically be breached, services denied, or parental permission required if they tried to access SRH services below the age of 16 years.

Furthermore, with confidentiality being found to be very significant for young people in promoting their access to services, their limited knowledge of the facilitative aspects of the law on this issue seemed to have a clear effect on whether they were likely to access certain services, especially for young people reliant on local services in rural areas or family GP practices.

Service providers perceived a lower level of knowledge of the law among young people than that demonstrated by the young people involved in the study. According to service providers involved in the study, young people's knowledge of the laws regulating sexuality and access to services is generally limited and quite skewed. Their knowledge of the law tends to be limited to basic principles and understanding of basic concepts, such as the age of sexual consent, but they tend not to have a more detailed understanding of relevant laws, nor how these laws would apply to them in practice.

> Young people in general have a very basic understanding about the law in general and sexual health. Sexual health is a new term and it is very difficult to contextualise it.[46]

Lack of knowledge of how laws apply in practice was seen to be particularly prominent where laws are not explicitly clear, such as, for instance, where the law does not prescribe an explicit age for ensuring access and/or where the application of the law is dependent on the exercise of professional discretion (for example, the law on consent to medical treatment).

> Young people would like the law to be straightforward. If there is a grey area, they don't really understand the law.[47]

In the absence of quality education on laws relating to sexual health, service providers reported that young people tend to have incorrect or out-dated information, or hold views that are based on (mis)information that their parents have "drummed into them" with the aim of encouraging them to delay sexual experiences.[48] Lack of knowledge was also seen by some service providers to be fuelled by the provision of misinformation on the part of service providers and other professionals.

> Lack of knowledge of rights and how to access them is a huge barrier… Young people are not told what their rights are. This is not covered in education. Some young people are told they aren't covered by the Equality Act if they are under 18…they are told they can't instruct a solicitor and are not told about "next friends".[49]

Where legal frameworks are permissive or facilitative of access to SRH services, lack of knowledge of the law and its application can operate as a barrier to access.

3 Education and access to information

3.1 Legal framework on sex and relationships education in schools

Laws that provide for compulsory sex and relationships education (SRE) and give guidance on what it should encompass and how it should be delivered can be seen as 'facilitative', as they can help to remove barriers to accessing SRH services. Accurate, comprehensive, age-appropriate sex education that is inclusive of all sexualities and sexual identities is essential to ensuring informed decision-making and self-protection of young people. Where effectively delivered, it can also assist in countering harmful stereotypes, increasing sensitisation and reducing stigma against LGBTI young people.

In **England**, the law provides for some compulsory sex education in all schools, and also provides for some SRE in non-compulsory subjects. However, the components of sex education that are compulsory are extremely limited. The sex education elements of the National Curriculum that are mandatory for all pupils are contained in the Science Order, and are limited to the biological facts of human sexual behaviour, including, in primary school, anatomy, puberty, biological aspects of reproduction and the use of hormones to control and promote fertility. In secondary schools, compulsory sex education includes (at a minimum) information about sexually transmitted infections (STIs) and HIV. Compulsory sex education, even at secondary school level, is not comprehensive and focuses almost exclusively on prevention of disease, which tends to reinforce the notion that sex is associated with victimisation, danger and stigma. Rather than encouraging healthy behaviour, research has found that this focus has the opposite effect: that *'perceived stigma is negatively associated with adolescents' likelihood of being screened for STIs'*.[50] Further, education that fails to *'interrogate relations of power, risk and desire limit the capacities of young people,'* and limits the scope of young people *'for critique, resistance and reporting of abuse, responsible engagement and enjoyment'*.[51]

In secondary schools, SRE is delivered through the Personal, Social and Health Education (PSHE) curriculum, which is more comprehensive than the SRE contained within the science curriculum. However, within this framework, SRE is also taught in a narrow way. According to Government guidance, SRE within the PSHE curriculum should:

- Teach about relationships, love and care and the responsibilities of parenthood as well as sex;
- Focus on boys as much as girls;
- Build self-esteem;
- Teach the taking on of responsibility and the consequences of one's actions in relation to sexual activity and parenthood;
- Provide young people with information about different types of contraception, safe sex and how they can access local sources of further advice and treatment;
- Use young people as peer educators, e.g. teenage mothers and fathers;
- Give young people a clear understanding of the arguments for delaying sexual activity and resisting pressure;
- Link sex and relationships education with issues of peer pressure and other risk-taking behaviour, such as drugs, smoking and alcohol; and
- Ensure young people understand how the law applies to sexual relationships.[52]

However, PSHE is not part of the compulsory curriculum, and so is not delivered to all students. In addition, parents have an absolute right to remove their child from SRE unconditionally.[53] This imposes a significant barrier to some young people's ability to access essential information that is necessary for their sexual health and well-being. It also has the effect of reinforcing '*a broader ideology that views sexual health information as "corrupting" innocent young people whose sexuality lies within the governance of the family*'.[54]

The law also imposes limitations on the framework for SRE and the modes of its delivery. Amendments to the law introduced in 2000[55] mean that schools are required to deliver SRE with due regard to the '*moral considerations of family life*'. Government Guidance – to which schools and governing bodies must have regard – provides that, while '*it is up to schools to make sure that the needs of all pupils are met in their programmes*', and that '*young people, whatever their sexuality, need to feel sex and relationships education is relevant to them*', that '*there should be no direct promotion of sexual orientation*'.[56] These provisions and guidance undermine the ability of schools to educate students about SRH that is relevant to LGBTI young people in an open and honest way. The provision against the direct promotion of sexual orientation would likely apply, in practice, to non-heterosexual orientation. Governors, Head Teachers and Teachers who are quite risk adverse may be concerned that teaching about LGBTI issues would be misconstrued by parents and/or pupils as promoting a particular sexual orientation.

The law is different in **Wales**. Under the Education Act 2002, SRE is a compulsory part of the basic curriculum in all secondary schools. Though SRE is not compulsory in primary schools, primary schools are also required to have a policy on SRE, and the Welsh Government does recommend that schools have a graduated programme of SRE. Compulsory SRE in Wales should, according to Government Guidance, enable learners to:

- Develop positive attitudes and values that influence the way they behave;
- Develop the skills needed to make responsible and well-informed decisions about sexual health and well-being;
- Gain respect for themselves and others;
- Appreciate diversity within sexual orientation and celebrate difference;

- Build successful relationships;
- Appreciate the importance of stable and loving personal relationships;
- Understand the physical and emotional aspects of sex, sexuality and sexual health and well-being;
- Understand the consequences and risks of sexual activity;
- Recognize the benefits of delaying sexual activity;
- Understand the laws relating to sexual behaviour; and
- Know how to get appropriate advice on sexual health and well-being.[57]

Compulsory SRE in Welsh schools is therefore likely to be more comprehensive and should allow young people to engage with the non-physical and reproductive aspects of SRH.

Similarly, legislation in **Northern Ireland** makes it compulsory to teach Relationships and Sexuality Education (RSE), in addition to the biological facts of reproduction. There is also no law permitting parents to withdraw children from sex education. The Education (Curriculum Minimum Content) Order (Northern Ireland) 2007 could be interpreted as being more facilitative than the law applying in England and Wales in terms of providing for mandatory inclusion of 'personal understanding' and 'personal health' as key elements to be addressed by all learning areas/subject strands, and through the specific requirements contained in the programmes for Personal Development and Mutual Understanding (primary) and Personal Development (post-primary). Personal Development and Mutual Understanding requires that children explore, inter alia, self-esteem, emotions, health and growth; Personal Development requires that young people explore issues associated with the themes of *'self-awareness, personal health and relationships'*.[58] The Personal Development strand for Key Stage 3 and 4 (ages 11–16 years old) comes under a compulsory component called, *'Learning for Life and Work'*, which includes statutory requirements to ensure that young people *'explore the implications of sexual maturation, e.g. sexual health, fertility, contraception, conception, teenage pregnancy, child birth etc; [and] explore the emotional, social and moral implications of early sexual activity, e.g. personal values, attitudes and perceptions, the law, STIs, the impact of underage parenting etc'*.[59]

By legislating for teaching which extends beyond the biological facts and implications of sexual activity, Northern Ireland has created a legal framework which promotes education that contributes to young people's increased understanding of and access to their sexual and reproductive health needs. Their curriculum looks to, *'empower young people to achieve their potential and to make informed and responsible decisions throughout their lives'*.[60] Unfortunately, however, this exploration of the multiple issues relating to young people's sexuality has not always materialised in individual schools' RSE policies. The law stipulates that schools must write their own policies relating to RSE, which should explore the implications of sexual maturation and the emotional, social and moral implications of early sexual activity; however, it mentions, *'sexual health, fertility, contraception, conception, teenage pregnancy, child birth … personal values, attitudes and perceptions, the law, STIs, the impact of underage parenting etc.'*, as examples only. Curriculum guidelines support teaching and discussing these issues; however, there is no legal obligation to do so and provision has been found to vary widely in practice[61] due, we were told by service providers, to differing levels of teacher training /skills and reluctance on behalf of schools to address what are still frequently considered controversial or taboo topics.

Additionally, there is no statutory requirement to teach on topics related to sexual orientation or gender identity in Northern Ireland. Non-statutory guidance recommends that teachers cover "Sexual Identity and Sexual Orientation" at Key stage 4 (14–16 years old), under the following description:

> The issue of sexual orientation should be handled by schools in a sensitive, non-confrontational and reassuring way.
>
> In the transition from childhood to adulthood, some adolescents experience strong emotional attachments and feelings towards people of their own sex. Many move on to form heterosexual relationships; some remain permanently homosexual or bisexual. Pupils should be reminded that a male under 18 years cannot legally consent to any homosexual act [this law has since changed].
>
> Teachers, whatever their own views, should counteract prejudice and support the development of self-esteem and a sense of responsibility in every pupil.[62]

This appears in the section headed, "Teaching sensitive issues", between the points on STIs and sexual abuse, the placing of which has been criticised for attaching it with negative and controversial connotations, while simultaneously undermining it as a mainstream issue for young people. The content is felt to be limited, inaccurate and suggestive that homosexual and bisexual feelings/ behaviours may be transitory/temporary, and moving on to form heterosexual relationships a more positive step for young people.[63] With schools not obliged to provide education on these issues, and teachers unsupported on how to do so impartially, there is a risk that schools may be reticent to address what is still considered a controversial topic by many individuals and institutions.

3.2 Findings: sex and relationships education in practice

3.2.1 Young people value SRE and see access to information as an extremely important component of good sexual health

In general, young people involved in the research in all locations considered comprehensive SRE to be extremely important, with some stating that it is the most important element of SRH. Young people linked increased education, especially from a younger age, to being better able to protect themselves from negative consequences of sexual activity.

> Are there any aspects of sexual and reproductive health that you think are more important than others?
>
> Personally I think I'd say, starting at the start gate with knowledge and, you know, making sure that people are aware of what's available to them, their options, their body. It might sound kind of basic, but a lot of people don't know how sex works.[65]

Quality, comprehensive SRE, and access to information more generally, was also seen as essential for ensuring that young people are able to make protective, healthy and informed decisions. It was often directly linked to the promotion of individual autonomy. Education was seen as being essential for: "*Making sure you know the implications and have a good understanding of how to keep yourself safe*";[66] "*helping make informed choices, knowing risks and implications of decisions*";[67] and "*empowering and helping them [young people]*".[68] Most of the service providers involved in the study also explicitly mentioned quality SRE as an essential component of good sexual and reproductive health; most perceiving that SRE can enable young people to make healthy, informed decisions.

The link between SRE and the promotion of autonomy and protective behaviours was illustrated by young people in one focus group through a perceived connection between education and consideration of what the age of sexual consent should be. The young people felt that, where comprehensive education is provided, the age of consent could be lower, as young people will be more capable of making informed decisions and safeguarding their own sexual health. There will therefore be less need for Governments to take a protectionist approach to restricting sexual activity through the law.

Conversely, lack of comprehensive SRE was seen to undermine the ability of young people to make informed decisions and protect their own sexual health.

"If there was going to be a priority, I think it's educating people across the broadest possible spectrum and that way allowing them to make choices for themselves, as opposed to saying 'we'll make the decision for you'."[64]

> I think that's where things go wrong in society. They're not aware, not being taught about being safe, not being taught about using a condom. Usually in school they get experts in, but not so much now, less than they did before. That's why there's so much teenage pregnancy.[69]
>
> They need to be told. Some people assume you know how to use stuff, know how to protect yourself, but so many people don't know, and it's like going into a situation blindfolded.[70]

Service Providers involved in the study expressed particular concern at the impact of lack of quality SRE. Lack of quality SRE was perceived to lead to poorly informed decisions and a reduction in the ability of young people to safeguard their own sexual health. According to some service providers, prevailing myths that young people have about SRH tend to go uncorrected in the absence of quality, comprehensive SRE.

> Sometimes the young people won't have even heard the name of different body parts, let alone all the laws around sexual behaviour, so sometimes you have to start from the very beginning. There are so many myths around sex and relationships that it can be very confusing. Sometimes young people lump these things together and just try to work them out for themselves by looking at a picture, rather than actually gaining a proper educational knowledge which is based on facts. A lot of it is hearsay or 'Chinese whispers'. So there are still age old myths around pregnancy, for example, "you can't get pregnant if it's your first time, or if you have sex standing up". A lot of people also think that you can get pregnant through oral sex.[71]

Some service providers perceived lack of quality SRE as putting young people in danger of catching STIs and contributing to teenage pregnancy: "*We also have higher rates of STIs, so the fact that so many schools are dismissive of SRE, is almost like a child protection or safeguarding issue which they need to address*".[72]

Some participants also linked quality SRE with a reduction of stigma associated with sex and sexuality. Some young people recognized the critical importance of good quality sex education for enabling "*a rounded understanding of sexual health being*

about both physical and mental well-being"[73], which was echoed by service providers, one of whom identified the most important issues relating to SRH for young people as:

> Information, sexuality and relationships education so that they can enjoy a healthy and safe sex life without any stigma or guilt or having to be ashamed or hide if something does go wrong. So I think information and education is the key.[74]

Quality SRE can play an important role in reducing the stigma surrounding sex among young people, helping to eliminate this barrier to accessing SRH services.

3.2.2 There was reported to be wide variation in the extent and quality of SRE in schools

As mentioned above, SRE is not part of the compulsory school curriculum in England, and service providers reported that there is a significant variation in the extent and quality of SRE among schools in the country, with some providing reasonably comprehensive coverage delivered in an engaging manner, and others delivering no or only very minimal instruction. In many schools, there is a perception among service providers and young people that the extent of SRE provided in schools is very limited: "*There are a number of schools that do fantastic sex and relationships education, and great programmes, but I can only name about three or four, and there are about 25 high schools in Manchester*".[76]

Service providers reported that there is wide variation in the level of knowledge of SRH matters among young people according to the school they attend or attended, as a result of this. It was perceived that, in schools with a good SRE programmes, young people had a much greater level of knowledge of SRH issues.[77]

> If we go to a private school, there is an expectation that they will have the most knowledge, but more often they're quite ignorant, but then there is often the idea that the more streetwise young people are going to have more knowledge, and their knowledge isn't quite there. So you can't just say "yes, they know" or "yes, they don't know" because there is such a massive variety – some people do, and some people don't.[78]

Most young participants expressed disappointment about the lack of effective SRE they received in school. Some young people could not recall receiving any SRE in school: "*(I had sex education) when I was in primary school, in like year 5 or something. It just wasn't relevant, I didn't understand it. Whereas when I got to secondary school I didn't have any, which I thought was quite weird*".[79]

Sex and relationships education in some schools appears to be taught in an isolated day or two, rather than in a more mainstreamed or systematic way. Some young people involved in focus groups reported having received a sex education 'day' or several isolated days, typically in the early years of secondary school: "*We learned stuff like that in school, but in about two lessons. I think there needs to be a lot more structured lesson plans*".[80]

> "I just found out the odd thing here and there… I had it once in about year 9. It was rubbish".[75]

SRE in some schools appears to be reactive and under-planned, rather than more formally structured and integrated: "*[I remember receiving] nothing. We only got taught when it all kicked off in school. Oh wait, we had one in year 10, but it got cut short as the teacher felt uncomfortable*".[81] This tends to reinforce the idea that sex education is something 'extra' or additional to the 'real' curriculum, which may have the effect of misrepresenting its importance to young people. The mode of delivery, which in some schools appears to be limited to several video screenings, reinforces this: "*I saw two videos – in year 9 and year 6, dealing with condoms, check-ups, seeing the school nurse and all that*".[82]

Some young people perceived that SRE commences too late in schooling.

> **YP1:** I think sex education needs to be taught at a much younger age as children are having more sex younger.
>
> **YP2:** I totally agree. I think the age should be around 12.[83]
>
> Participants generally felt that this was necessary to ensure that younger people are able to protect their sexual health.
>
> We had 12 year old teenage pregnancies happening because they just didn't know. They hadn't reached that gate in their education where "now it's OK"… In terms of whether education is really available, until that point, not really, and so you would have people who would have sex for the first time, in fact I know people who had sex for the first time without contraception because they didn't know why they needed it.[84]

Perhaps as a result of the limited focus of SRE in schools, many young people did not see the SRE they received in schools as relevant or 'realistic':

> **YP1:** I think everyone should have sex education lessons, but the sex education lessons they give you have nothing to do with the real sex that happens.
>
> **YP3:** Definitely. They don't make it realistic enough.[85]

Where SRE is perceived as irrelevant, or not having application to the lives of young people, young people are unlikely to engage with it and this will undermine the effectiveness of SRE.

SRE is considered to be of good quality where it is engaging and relaxed.

> You get some [schools] where they basically have nothing, except for the biological aspects in biology lessons and, from listening to young people, where it is interactive and where the trainers are able to do it so it's in a dialogue and it's relaxed and fun and interactive, it seems like they've enjoyed it more. If you get someone who's embarrassed and uncomfortable, it has a knock on effect really.[86]

SRE delivered by external specialists was particularly valued by participants in the study: *"As it's Brook coming in, it isn't your science teacher; it's by people who are trained to talk to young people about sexual health, so it feels more comfortable and interactive"*.[87]

Several LGBTI young people mentioned positive and engaging experiences with SRE, particularly where this was delivered by external providers, in a relaxed and interactive way.

> See, my experience of sexual health in my school was alright compared to what I'm hearing, because we did cover some. There was a lesson just dedicated to homosexuality and there were leaflets from Brook, because they do a lot of informative leaflets and they are really easy to leave [with the young people] and really fun booklets. It was alright, and I know that my best lesson of sexual health was when we actually got the penises and we put the condoms on and we put blindfolds on to see if we could do it in the dark. That was pretty fun.[88]

The lack of SRE provision was perceived as being similarly inconsistent in academies, free schools and faith-based schools. Academies are schools in England that are directly funded by central Government (and can also be funded privately by personal or corporate sponsors), and they are not controlled by the local authorities, which control other state-run schools. Free schools are funded by taxpayers, but not controlled by the local authority. Faith-based schools are State-funded schools with a particular religious character, or which have formal links with a religious institution. These types of schools must all teach the National Curriculum. However, as mentioned above, SRE does not form part of the National Curriculum. According to young people and service providers, provision of SRE in academies and faith-based schools in England can be extremely limited.

> Young people who have a school that's really hot on their PHSE and sex education, they do have more knowledge and we always ask questions, like "do you know how to put on condoms" – "yeah we did it at school – we were practising on bananas last week". You'll have that, or you'll have someone who doesn't talk about it. You'll ask if they know how to put on a condom and they'll say no, "do you ever talk to anyone about it? At school?" "no", or "yeah, we had Brook in last week", but sometimes, "no", and that's usually Catholic schools, Faith schools.[89]

> The government published guidelines, so academy schools don't have to do anything if they don't want to; there is no impetus there. [SRE is] very restricted in terms of timetables because of core subjects, which is what they [schools] get measured on and that is never going to go away so they don't schedule in time to do any kind of SRE in schools and quite often whole year groups don't have anything at all. Academies don't have to have a policy on what they deliver, because at least in mainstream, state funded schools, they've got to give some sort of reason and go through their governors, and there is an understanding there. But in the free schools and academies, they can just say no, and that is really worrying because it is completely dismissing any kind of need.[90]

The delivery of SRE in some faith-based schools was perceived to be carried out in a negative way, reinforcing the stigma surrounding sexual activity among young people. This was perceived, by some service providers, as having a very negative impact on young people who have used particular SRH services.

> The experience of young people who attend Roman Catholic schools is massively different. I mean, the SRE is different. I had one young person who came in who was 14 and pregnant and she had counselling for quite a few months from me because she just had the same reoccurring dream every night where she was a murderer, because the way they taught at her school about abortion, about it being murder and stuff like that, she was really messed up by that. What they taught about abortion in their lessons was very upsetting for her because obviously she'd had an abortion.[91]

Interestingly, inconsistency in the extent and quality of SRE was also reported in **Wales** and **Northern Ireland**, where participants expressed views ranging from their SRE being "good" to "OK" and "crap" (completely lacking in relevance and limited to biological aspects of sexual health).

> Did you learn enough about sexual health at school?
>
> No, not at all. In school, it was rubbish.[92]
>
> I had a little bit of sex education at school, but I think it's limited in what they can tell you in school without parents saying, "that's too much information".[93]

This could perhaps be explained by the age of the participants in the study – SRE became compulsory in the Welsh curriculum in 2002, when some of the participants would already have completed the level of their education subsequent to the introduction of compulsory SRE. Nonetheless, service providers also expressed continuing disappointment about the quality of SRE in schools in Wales.

> It never fails to amaze me how naïve the women are – even though they have children – about condoms, the pill, STDs… I don't know what sex education they're getting in schools, but it's obviously not really getting the message across.[94]

In Northern Ireland, while young people mostly named school as the primary source of knowledge about sexual health, they simultaneously described the provision of sex education as, "non-existent" or insufficient.

> We have compulsory RSE, but it is taught in a very ad hoc kind of way. Some schools are very good at teaching it and others aren't, so some people will be better able to access information, but it's a whole myth that young people are well informed and educated in sexual health matters, and adults believe that, but that's not true. Until you're talking to a young person about what they know, and then you realize what they don't know.[95]

The young people involved in the study in Northern Ireland had experienced RSE at a variety of ages and to varying extents. Only one young person had received education as young as 13 years old, with most remembering lessons taking place at some point between the ages of 14–16 years at varying regularity. Some recalled receiving only one or two lessons in total, with others having received instruction on an annual basis for a varying number of years.

There was a feeling from some young people in Northern Ireland that SRE was not sufficiently responsive to the reality of young people's sexuality and was not being taught at a young enough age to reflect when many people were starting to engage in sexual activity.

> Whenever my school were giving the sex talk, there were about two girls already pregnant.[96]

Every young person in Northern Ireland seemed to know of a girl becoming pregnant under the age of 16 years; however, the normative belief that talking about sex encourages promiscuity may be one of the reasons young people's sexuality in general is not discussed openly, and seemingly not discussed at all with under 13 year olds: "Security through obscurity – it never works".[97]

"Schools take the easy way out. If it's too difficult for them, they won't do it. They obviously have to teach about SRH, but so they think, 'we'll only do the biology side', and then they get different people in to talk about STDs, usually from faith groups".[98]

3.2.3 The content of SRE in many schools is limited to the biological aspects of sex and reproduction and disease prevention

SRE in many schools across the UK appears to be focused on the physiological and reproductive aspects of sexual activity. Education about healthy relationships and emotional elements of sexual health was perceived to be greatly lacking. Many young people reported that the sex education they received in schools focused on preventing STIs and unwanted pregnancies and explaining the reproductive aspects of SRH: "*I remember the first thing they showed us was a woman giving birth…they also taught us about condoms. I remember they taught us how to put it on. STIs – we learnt a lot about that*".[99]

Schools are not obliged to provide education on the broader dimensions of SRH in England, including on healthy relationships and issues of violence and consent, and this was perceived as undermining the ability of young people to have healthy and enjoyable sexual lives and relationships.

> Unfortunately, the two main high schools in that area [East Manchester], both of which have big populations (e.g. 12 classes in one year group), they've just taken SRE off their curriculum completely. All that I am aware of is that they deliver a lesson in science about contraception and HIV and that is it. So when we ask why is the under 18 conception rate so high, we just have to look at the education. A lot of the youth providers in that area as well say that they have had lots of training about STIs but there is nothing to increase their understanding of the age of consent or what the laws about sex are and how it affects them.[100]

The very narrow focus of SRE in many schools appears to have had the effect of limiting young people's conception of what SRH is and what it includes. When asked to define SRH, the majority of young people participating in the research provided quite narrow definitions, limiting SRH to a list of contraceptives or a list of services that they felt were essential in treating specific problems (STIs); disconnecting these services

from broader notions of healthy relationships and protection. Some service providers also perceived that young people view SRH in a disjointed way, and that they do not relate it to other aspects of being healthy.[101]

There were exceptions, however, and this was mostly from older groups of young people who had had some level of active engagement with sexual health providers. These young people tended to define SRH in a more comprehensive way, as "*health advocacy, awareness and healthcare services around sexual organs*";[102] "*every aspect of sexual intercourse and reproduction, from the relationship, to the act and everything in-between*";[103] *"being respectful of people, whoever might be involved in whatever sexual act"*;[104] and "*it is also the psychological side; making sure each party is ready, knows the full implications, it is safe…*"[105]

Some service providers linked the absence of education about relationships and violence to a lack of capacity of some young people to identify signs of abuse and violence within relationships. Sexual violence within relationships is linked to broader issues of power and control, and violence appears to be a problem in relationships where there is an element of existing control, and of isolation and bullying.[106] Educating young people about SRH without addressing healthy relationships and issues of violence and control, risks undermining the ability of young people to identify unhealthy or abusive relationships.

> A lot of young people are very confused about what domestic violence is and this is the biggest barrier to getting support. Some young people think domestic violence is part of a 'normal' relationship.[107]
>
> Relationships education is so vital… A lot of young girls think it's OK to be treated badly and a lot of guys think it's OK to be treating girls badly… Sex and relationships education is the only thing that's going to change it. I think there's a massive need for it.[108]

Interestingly, the results were similar in Northern Ireland, despite the legislative framework incorporating elements of emotional, mental and social implications of sexual activity into compulsory SRE. Young people felt that in school, content mostly only covered "the biological", or was limited to inputs on contraceptives, STIs/STDs and pregnancy. No one said their education had been sufficient, and discussions around consent and relationships were thought to be lacking, even though the requirement to discuss the latter is enshrined in law. Young people were frustrated by schools' interpretation and delivery of sex education, which often did not seem to align with the statutory requirements of the law relating to SRE: "*Ours wasn't about sex – only about periods – it was biology not sex-ed!*"[109]

> "You get biological [content] in school and then you get someone coming in, usually from a church / faith group, and they'll come in and say, 'don't have sex; don't have sex; don't have sex', if you do you'll get AIDS and you'll die".[113]

Young people emphasised the importance of being both mentally and physically prepared for sex, but felt that education did little to address the non-physical aspects of SRH:

> **YP1:** Puberty is getting younger and younger and your body starts telling you around those ages to start having sex so even if you're not mentally ready, there needs to be more support for the mental health side of it, instead of just talk around STIs or pregnancy or contraceptives. Has anyone ever heard anything in schools about mental health side of it?
>
> **YP2–8:** No *[echoed by whole group].*[110]

One young man commented that there was, "*nothing preparing you for how awkward the first time can be*",[111] which formed part of a broader conversation within the same focus group about the closed attitude of education towards discussing, "*having sex not just for having babies, but for pleasure*".[112] LGBTI young people in particular felt that education was focused limitedly on the reproductive aspects of sexuality, and one of the service providers also brought up the reluctance of schools and other institutions to discuss sex in terms of 'enjoyment', due to concerns that they would be seen to be promoting promiscuity.

3.2.4 In Northern Ireland, the provision of quality RSE was strongly influenced by religious norms

Young people from both faith and non-faith schools reportedly received RSE that appeared to be influenced by religiously conservative cultural norms and schools often relied on external organisations, such as faith-based groups, to deliver RSE to students:

> All schools in Northern Ireland, from both sides, have this religious ethos, and you can't really get away from that. Mine wasn't a faith school but the people who came in to talk about sex were from a faith group.[114]

This seemed to result in young people receiving strong messaging regarding the importance of abstinence, and the negative consequences and connotations of engaging in sexual activity at a young age.

This negative and limited approach to discussing sexual activity was felt by some young people to be leaving them ignorant of important SRH issues, and, according to service providers, was misinforming them about others, e.g. abortion.

> The RSE programme includes healthy relationships, which may be compulsory, but people aren't doing it and so it doesn't really mean anything. You can, within the ethos of the school, leave parts out, and schools don't have to do work on abortion or homosexuality or services. Quite a few schools will do bits on abortion …but it's taught in line with the school's morals and beliefs, and the organisations that support an anti-choice position will get into schools much easier than those who are pro-choice.[115]

Schools were said to be varying RSE content based on their own moral ethos and many schools appear not to be adhering to compulsory RSE legislation at all (with reportedly little pressure to do so).

Furthermore, while schools are not legally required to teach or discuss abortion, as discussed above, young people and service providers commented that they would often do so, and this would usually be in line with their own morals/beliefs, which would be more commonly aligned with anti-choice groups than pro-choice ones.

> We learn about health and safety of baby and how bad it is to give it up for abortion, about how you can be peer pressured into doing stuff you don't want to, like being pressured to have an abortion and how you could stop that.[116]

Stigmatising or approaching SRH issues, like abortion, in this manner may impact negatively on young people's likelihood to seek help and advice when faced with their own sexual health problems and needs, limiting their perceived options.

Both service providers and young people felt sex was not talked about openly in schools (or elsewhere in society), with discussions about sexual activity being seen as encouraging promiscuous and morally unacceptable behaviour. Service providers gave an example of schools' reluctance to broach the topic of sex, citing a recent incident where HPV vaccinations had been administered in schools for twelve year old girls. These only work on the premise that the recipient is not already sexually active. Service providers were frustrated to learn that schools were not telling young people what the vaccination was for, feeling that this was not only a missed opportunity to further inform and educate young people about sex, but was also taking too much of a protectionist stance, leaving young people no autonomy to make decisions regarding their own bodies. It shows a lack of trust in young people's capacity to understand and absorb information regarding sex and relationships from a young age, viewing any discussion about these topics as automatically promoting promiscuity. In this situation, if any of those twelve year olds were already engaging in sexual activity, not only have the schools missed an opportunity to give them tools of understanding to make them safer, but the vaccination itself is rendered redundant.

> "I don't think my school is homophobic, but it thinks everyone is straight and so doesn't provide any information on everything else".[117]

3.2.5 There is a lack of SRE relevant to LGBTI young people

The vast majority of LGBTI young people involved in the study reported that the SRE delivered in their school did not provide them with information on sexual health issues that apply to them, as SRE is based on the premise that all students are heterosexual:

> All my sex education classes at school were about heterosexual relationships and the odd healthy relationship one that we'd occasionally have.[118]

> Sexual and reproductive health education at school but was terrible. We didn't learn anything. It was ridiculous. I just felt like – I don't need to know that – what are you talking about? My biggest problem at the time was that it was very heteronormative. It was just like, well this doesn't apply to a lot of people so what is the point? It's just a waste of my life.[119]

Some young people reported that SRE was delivered in different classes according to gender in their school, which excludes engagement with non-heterosexual and non gender-binary identities: "*I was stuck in a classroom full of girls learning about the uterus and how that works and I had gone to visit the guys who were in another room learning about the penis and how that goes into a vagina*".[120]

There was also discussion of different methods of delivering the classes in Northern Ireland, with a small number reporting receiving sex-segregated education: *'You're only told about your own sex – we were separated'*.[121]

Separating girls from boys in this way fails to recognize the needs of transgender, third gender, intersex and genderqueer youth. It also serves to aggravate existing closed attitudes towards sex and increase the reticence among young people to talk about the issues affecting them. It is likely to further entrench gender norms,

especially if groups only receive information deemed relevant to their sex, leaving them ignorant of wider issues.

Even for young people who perceived that their SRE was comprehensive, they expressed concern about the lack of education on non-heterosexuality:

> Out of all our sexual health things, and the sexual related activity, that's the one that is the least talked about. We don't really cover it in school, and not even really… unless you go on the NHS website, there isn't really a load of access to information about it. It's more about stereotypes and what people believe gays are like and what lesbians are like and things like that. There's not really clear information about it.[122]

Where school SRE has included LGBTI issues, the mode of delivery can further marginalise non-heterosexual young people, and foster an environment in which LGBTI identities are seen as 'abnormal': "*In my school, you never get the sense that it's normal for girls to like girls. We are taught some information about it, but it's always in the sense that it's 'abnormal'*".[123]

It appears, perhaps as a consequence of concerns that teachers should not be seen as "promoting homosexuality", that schools may be reluctant to engage with LGBTI issues, and will only focus on quite basic, less controversial factual information relating to heterosexual sexuality. According to some service providers, there is prevailing confusion among teachers, with some holding the belief that they cannot talk about homosexual relationships at school, or be seen to be supporting an LGBT young person.

> When a boy at my school was excluded, I tried to talk to the head of sixth form about it and he said that he had to be really careful when he talked about it and how he reacts to homophobia, because he "can't be seen to be encouraging homosexuality." I come from a really good school and if that teacher said that to me there, imagine what happens in other worse schools. If the kids are being bullied, a teacher might not feel like they could act for fear of looking like they're promoting being gay.[124]

> When I did my campaign about homophobia, I did it about celebrities and awareness-raising instead of "having a go", just tried to highlight the issues. I was warned off doing it by teachers who said I'd just get bullied more for it, but I did it anyway and it actually turned out fine… I think the teachers were frightened about how kids would react, and it actually turned out fine. I got loads of applause and everyone was really quiet throughout. I think teachers were frightened about how kids would react, probably because they don't understand the issue. I had to explain bisexuality and pansexuality, and once I'd explained that it means I like people for who they are, not just based on what they look like or their gender, no one could really argue, because it's just a good thing. They just needed it explained to them.[125]

The role of parents and communities in the governance of non-state schools that are religious or particularly conservative may create a particularly restrictive environment in the delivery of SRE.

> The school tends to be the point for people to get information: at assemblies or in class. But depending on which school you go to, if you go to a strictly religious or conservative school, it might be eschewed…it's not necessarily the policy but you might not get certain things so as to avoid rocking the boat, and unfortunately, a lot of people take this approach and don't rock the boat, that is just to cover the bread and butter and then keep going… some schools just avoid getting involved.[126]

Some young people also perceived that there was prioritisation within LGBTI issues in relation to SRE and information more generally, with information relating to lesbians, in particular, being marginalised by schools and service providers: "*It seems to be a pecking order in terms of gender orientation, sexual orientation in society. And sex education for lesbians is basically little to none, because [it is thought that] you can't get sexually transmitted infections*".[127]

Schools in Northern Ireland are not legally required to teach on any issues relating to LGBTI identity. The curriculum guidance, as noted above, does encourage that, '*the issue of sexual orientation should be handled by schools in a sensitive, non-confrontational and reassuring way*'.[128] However, some young people felt that, "*If schools don't have to talk about it, then they won't*".[129]

The research not only highlighted a reticence by schools to address these issues, but two separate young people had experienced teachers being actively prohibited from engaging with the topic at all.

> My teacher put up a poster about LGBTI issues but then next day it was down, so obviously someone told him to take it down. It wasn't propaganda, just history.[130]

> In my school the sex talk was in 4th year and there was a teacher who I really trusted who I went and asked about stuff and he said, *"please don't ever ask me that again, I will lose my job if I answer that question",* because of the people who pay for the school, 'cos they're all religious.[131]

LGBTI young people in Northern Ireland found that this absence of information relevant to them strongly (negatively) affected their access to SRH services, since schools focused heavily on

preventing pregnancy and STI spread between heterosexual partners, with little discussion of STI transmission between same sex partners:

> There's still high risk of catching STIs for LGBTI people because in school you're told you should wear a condom to prevent pregnancy, but nothing about stopping STIs and LGBTI people don't worry about pregnancy.[132]

For children in the UK who are LGBTI or exploring or questioning their sexuality, the lack of information does not assist them in understanding LGBTI sex and relationships, and directly impedes their ability to make informed, healthy decisions, which can have very negative physical and psychological impacts on young people.

> They don't teach about other sexualities, transgender, transsexual, you don't know about that. So when you leave secondary school, you're like, oh my god, there's this and there's that, I didn't know that, what are these feelings? You don't know nothing. That was my experience. I didn't know about no gay or nothing, because you don't learn about it; you hear about it, but you don't know about it.[133]

> I think with sexuality, I don't think that's promoted enough as well. In terms of being straight it is, but in terms of young people that might be going through a stage where they don't know what sexuality they are, I don't think there's enough information and it's not promoted as much.[134]

A low level of knowledge on issues relating to diverse sexualities and gender identities among almost all the young people in the study, apart from those engaged with LGBTI youth groups, was observed. The vast majority of young people had not learnt about or discussed these issues in an educational setting before. Lack of knowledge and awareness of LGBTI issues can leave harmful stereotypes unaddressed, and can create a less sensitive and more restrictive environment for LGBTI (young) people more generally.

3.2.6 In the absence of comprehensive SRE, young people are turning to alternative information sources

In the absence of comprehensive SRE, it is inevitable that young people will turn to alternative sources to seek out the information they feel is 'missing'. Young people involved in the study reported that they use a variety of alternative information sources to access information about SRH. These sources varied in quality and reliability, and included service providers, friends, parents, and mass media, including television, magazines, and in particular, the internet. Some young people sought information and advice from reputable SRH providers, in particular, LGBTI young people,

"I learnt about straight sex before I learnt about gay sex. And I only learnt about gay sex through porn. I don't think that's right. I don't like the idea of 12 year olds learning that way".[135]

who felt issues relevant to them were often marginalised in their school's SRE.

> You often find that a lot of people who reach out to services, you have to do your own homework. I think a lot of the time, when you're coming from an LGBTQIA[136] or spectrum background, the information is there, but you have to go the extra mile to find a lot of it, which is unfortunate.[137]

> It's appalling, totally appalling. All my knowledge of transgender comes from Mosaic. It takes someone to explain for people to understand.[138]

Reliance on service providers for information may not be possible, however, where young people live some distance from these providers:

> Education only covers straight sex, none about gay sex. If you want sexual health advice, you have to go to the school counsellor or you have to go to the clinic at the hospital, but that's really difficult or impossible to get to via public transport, so you can only really get to it by car, but most young people don't have a car.[139]

It appears that many young people get information about SRH from the internet. According to service providers involved in the study, the internet, and in particular, social media websites, are becoming the main source of information about SRH for young people, attributed, in part, to the proliferation of smart phones among young people. This is potentially damaging, as some young people may not be able to identify sites that are reliable from those that are not, and they may be exposed to misinformation or may access sites that compromise their safety.

> As a young gay man, I found it almost impossible to get information that was applicable to me. So [I got information] almost exclusively from the internet.[140]

> The internet doesn't judge … although there is a risk of course of just getting complete nonsense.[141]

Young people were conscious of the unreliability of information, the negative aspects of learning about sex from pornography, and the risk of self-diagnosing sexual health problems incorrectly from the health websites; however, some felt that they had no other way to access the information.

> Where did you learn about SRH?
>
> **YP1:** From the internet.
>
> **YP2:** It's impossible not to know about sex if you have the internet.
>
> **YP3:** But then you're getting a tainted view of it.
>
> **YP4:** A lot of people learn about sex from porn and it's not a real view.
>
> **YP5:** I ended up learning most of what I know from a website called scarletteen, because I could trust it more than my teachers.[142]

Service providers discussed their own knowledge of young people taking recourse to the internet, highlighting the reluctance to seek advice from teachers and parents, and describing accessing information through the internet as having both potentially positive and potentially negative consequences for their SRH.

> Does this have a good bad, or neutral affect on access to SRH do you think?
>
> Could say all three. It's good that they're going out of their way to try and access them. The other end of the scale is what sort of information you're accessing because a lot is not correct so could neutralise the benefits. But you would hope while they're searching for info that they would find organisations who could guide and support them. So at least they are aware that there are services there to support them.[143]

Getting information from friends or peers may not always be reliable and may also expose young people to misinformation.

> Some people don't have a lot of friends, so within their little peer groups, they just know one thing and that's it, so when one of them does go out and have sex, they don't know much because within that peer group they just don't have the knowledge. So if they do have an STI, they don't know what to do, 'cos it's not been promoted, it's not out there as it should be.[144]

4 Legal principles governing access to services

4.1 Age of sexual consent

4.1.1 Age and consent to sex: the legal framework

The 'age of sexual consent' is an age below which specified sexual activities are regarded as illegal, regardless of whether the child has given factual consent. The age of sexual consent in the UK is 16 years for both boys and girls. Below this age, the law deems a person unable to consent to any sexual activity, and so the Prosecution does not have to prove factual lack of consent. It is a defence if the person reasonably believes that the child is over the age of 16 years (however, this defence does not apply to cases in which the child is under the age of 13 years).[146] In effect, the law criminalizes the activities of a child or young person, including a young person under 16 years, if they engage in any sexual activity with a person under the age of 16 years. However, according to the Guidance of the Crown Prosecution Service, which guides the decision-making powers of Prosecutors: "*the overriding purpose of the legislation is to protect children and it was not the Parliament's intention to punish children unnecessarily or for the criminal law to intervene where it was wholly inappropriate. Consensual sexual activity between, for example, a 14 or 15 year old and a teenage partner would not normally require criminal proceedings in the absence of aggravating features*".[147]

However, particularly in cases in which the child is under 13 years, the Crown Prosecution Service may make the lawful decision to prosecute a young person. In 2008, the House of Lords considered the case[148] of a 15-year-old boy who was convicted of rape of a child under 13 years after having sexual intercourse with a 12-year-old girl whom he believed to be 15. For the purposes of sentencing, the prosecution accepted that the girl consented in fact and that she had said she was 15. Neither of those factors amounted to a defence, however, because the offence is committed if a person intentionally has sexual intercourse with another person and that other person is under 13 years. The attitude of the victim towards the act is irrelevant, as is the perpetrator's belief as to the victim's age. By a narrow majority (3–2) the court decided that the prosecutorial decision in the case before them was justified. All of the Judges agreed that there were good policy reasons for a clear law, which conveys the message, not only to adults but also to children, that sexual activity with a child under 16 is an offence.

In **Northern Ireland**, the Sexual Offences Order 2008 introduced a definition of consent: '*a person consents if he agrees by choice, and has the freedom and capacity to make that choice*'.[149] The Order contained a number of new provisions intended to better protect under 16 year olds from abuse. It simultaneously adjusted the age of consent for girls, making it 16 years old for both sexes (it had previously been 17 years for girls), and criminalising any sexual activity with persons below this age, regardless of whether factual consent is given. This is the case not only for over 18 year olds, but also for under 18 year olds. Though there is understanding in the explanatory guidance that the prosecution of children and young people may not be in their own best interests, or the public interest. Like England and Wales, the law in Northern Ireland provides that, "*a child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity*".[150]

> "I think it's immaterial what age they are. I don't know of many people who, before having sex, have questioned whether they are legally allowed to do so".[145]

The UK sets the age of sexual consent at a relatively high age, effectively criminalising all persons – including young people – for engaging in any sexual acts with those under 16 years. While the law may ostensibly have a protectionist aim, the fact that it does not apply solely to adults as perpetrators suggests that it also aims to regulate and restrict consensual sexual activity among young people. Fear of prosecution or being perceived as having broken the law or "done something wrong" could, in principle, put young people off accessing SRH services where they and/or their sexual partner is under the age of 16 years.

4.1.2 Research findings: the age of sexual consent as a barrier to SRH services

The legal age of consent does not appear to create a significant barrier to accessing sexual health services in the UK. There appears to be several reasons for this. Young people involved in the research generally had a good level of knowledge of what the age of sexual consent is in England and Wales, including the youngest participants (13 and 14 years); however, there was some confusion in Northern Ireland among young people about whether the age is 16 or 17, perhaps as a result of the recent change in the law. Most young people were aware that there had been a change in the law but no one said they thought this had impacted on young people's sexual behaviour.

> Do you think the change in the law relating to the age of sexual consent has affected the age young people engage in sexual activity?
>
> I wouldn't think so; they weren't sure what age it was initially, I think it depends on the nature of the relationship at the time, rather than on the age of consent.[151]

While many young people knew the age of consent, they did not understand the implications of the law, including that they would

be committing a criminal offence if they engaged in sexual activity with persons under 16 years. Young people were not very clear on when someone under the age of 18 could be prosecuted, and did not seem to think there was a realistic threat of prosecution.

> I think if two 15 year olds want to – they should go ahead!
>
> **And would they be legally allowed to?**
>
> I don't know whether they'd actually be done for it or not.[152]

Some young people were incredulous that, for instance, if they had a 17 year old sexual partner and they were 15, that this was illegal and the 17 year old could be prosecuted. They therefore did not view the law as being capable of being enforced.

> **Does the law [on the age of consent] matter?**
>
> *[scoffs]* No. No one cares what the law says. It's not enforced. What are they doing to do? Bang you up for banging?[153]
>
> **If someone under the age of 16 has sex, can they be prosecuted?**
>
> No; course not, then you'd have people in prison who were in for murder, and assault, and then someone there who was in for anal *[laughter all round]*.[154]

Some LGBTI young people lacked awareness of how the age of consent related to them, feeling it might be differently applied in relation to same-sex sexual activity than to heterosexual sexual activity.

> **Does the law say anything [about the age at which you can engage in sexual activity]?**
>
> **YP1:** Not if you're a lesbian it doesn't.
>
> **YP2:** The age of consent is something like 15 or something.
>
> **YP3:** I think it's 17 for a gay man.[155]

Young people also typically perceived that the law does not have an impact on them, or on their decision-making on sex and relationships. While age was clearly one of the most important factors to young people in deciding whether to engage in sexual activity with someone or not, young people discussed making their decisions about sex based more often on the nature of their relationships and their differing stages of maturity, with cultural and social norms seeming to play a larger part in their choices than the law. The vast majority of young people and service providers did not think that the age of consent was having any significant effect on young people's sexuality at all and, although they were aware that under-age sex was illegal, they did not think it likely that someone under 16 years old would be prosecuted.

In some cases, young people reported that the age of a potential partner was relevant as the legal age of consent is 16 years; however, this was commonly expressed as informing a moral imperative, rather than being motivated by fear of being charged with a criminal offence. Even where young people reported that the law was a relevant factor in the decision of whether to engage in sexual activities with a person, they also tended to say that the law would never stop a young person from having sex with someone under 16 years.

> Primarily, it comes down to the law that prevents me from having sex with anyone until the age of 16, but there is the moral issue, in that I am nearly 26, so for me to be having sex with someone who is 16, I see 16 year olds as children, as younger people with school uniforms, so morally it wouldn't compute.[156]
>
> I wouldn't say that the law would bar people [from having sex under the age of consent], it's more social stigma.[157]
>
> Setting a higher age [of consent] wouldn't stop young people from having sex.[158]

The law in Northern Ireland, while being a reflection of social, cultural and religious norms in many ways itself, does not seem to play as large a part in young people's conscious decisions than their own, their peers, and wider societies' views on when it is appropriate to engage in sexual activity. There is still a dominant social norm promoting no sex before marriage, and concurrently there are strong views around sex outside of relationships with the stigmatized view of 'promiscuity' being attached to any kind of sexuality among young people. It seems likely that these normative views are playing a larger part in young people's decisions than the law, although we know that, regardless, there are still significant numbers of young people engaging in underage sexual activity.

The age of consent is therefore not perceived to be a significant barrier to young people accessing SRH services:

> The age of consent is not something they acknowledge too much as "if I have sex under 16 then I'm going to go to prison". They don't see it like that, so the age of consent is not a deterrent. And also, they just don't know what the law is or is about in general.[159]

Some young people across the UK also perceived that service providers were not permitted to refuse them access to services even where they had committed an offence: "*But in any case, they [a service provider] can't refuse to give you help because the point is that you can't be refused treatment because you're breaking the law*".[160] According to service providers, young people have received the message that they are entitled to access services from any age, regardless of the age of sexual consent:

"So much work has gone into promoting the policy that the age of consent is 16, but you can access services at any age".[161]

Confidentiality duties of service providers also appear to have limited the potential barrier that the age of sexual consent could create for young people accessing SRH services. These duties prevent service providers, in most cases, from reporting to authorities where a young person, or their partner, has engaged in sexual acts with a person under 16 years.

> **Before the age of consent, which is 16, it is technically illegal to do any sexual activity. Do you think that prevents young people from accessing services, if they think "I am not meant to be doing this?**
>
> Not really, because if they have sex, they go to these clinics where [there is a duty of] confidentiality.[162]

The age of consent does not, therefore, appear to be acting as a direct barrier to accessing SRH services in the sense that young people do not fear prosecution for disclosing to a service provider that they have been engaging in sexual activity with a partner below the age of 16 years. However, knowledge of the law on the criminalisation of sexual activity below the age of consent appears to have an effect on young people's perceptions of access and confidentiality within sexual health settings, with some young people feeling that services might be denied, parental permission required, or confidentiality breached if the person was not legally allowed to be engaging in sexual activity:

> I think there's a certain age where you can't get things like that, they'd have to ring your parents or something.
>
> I think you'd have to be 16 since that's the legal age to have sex.[163]

The criminalisation of underage sexual activity, combined with a lack of clarity among young people on what the law regarding the age of sexual consent relates to, has led at the very least to confusion, but could also be inhibiting others from accessing the services they want and need.

4.2 Consent to SRH treatment

4.2.1 Young people and consent to medical treatment: the law

The law relating to consent to medical treatment is not set out in legislation in the UK, but rather is contained in common law, and there is no explicit age set out, in law, above which a child will be able to consent to medical treatment. Common law provides that any competent young person in the UK can consent to any medical, surgical or nursing treatment, including treatment relating to sexual and reproductive health.[164] Young people aged over 16 years are deemed mentally competent to consent to medical treatment.[165] Children under the age of 16 years must be assessed by a service provider as being of sufficient competency in order to consent. The law in this area is largely derived from a House of Lords case commonly referred to as 'Gillick',[166] which set out the relevant legal principles and guidelines ('Fraser Guidelines') that decision-makers should follow in determining competency of a person under 16 years to consent to medical treatment. Where children are deemed not competent to consent to treatment, a person with parental responsibility must consent on their behalf, before the young person is able to access the treatment.

The Gillick case involved a mother who took a court action against her local authority and the Department of Health and Social Security in an attempt to stop doctors from giving contraceptive advice or treatment to her daughter (with implications for consent to treatment for under 16-year-olds more generally). Mrs Gillick's claim was dismissed and this was upheld on appeal to the House of Lords. The court held that:

> …whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.[167]

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgement:

> …a doctor could proceed to give advice and treatment provided he is satisfied in the following criteria:
>
> 1. that the girl (although under the age of 16 years of age) will understand his advice;
> 2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
> 3. that she is very likely to continue having sexual intercourse with or without contraceptive treatment;
> 4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; and
> 5. that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.[168]

This case was specifically about contraceptive advice and treatment, but the case of *Axon, R (on the application of) v Secretary of State for Health [2006] EWHC 37 (Admin)* makes it clear that the principles apply to decisions about treatment and care for sexually transmitted infections and abortion, too.

The law therefore gives a service-provider discretion to determine the boundaries of consent to medical treatment, including, for instance, contraception, STI testing and treatment and pregnancy care, though the exercise of this discretion should be guided by the common law.

4.2.2 Research findings: the law on consent to treatment as a barrier to services

According to service providers involved in the study, young people attempting to access SRH services would only very rarely be deemed unable to consent to SRH treatment in practice, and this law was not seen as being a significant barrier to accessing advice and treatment. Service providers appear to be satisfied where, on talking to a young person, they "understand what they are saying" and several service providers mentioned using pro forma guidance to determine whether a young person is 'Fraser competent'.

> We have had to do that, in that we've had to talk to someone, it's very rare that that happens, very rare that we wouldn't be able to issue a form of contraception because we didn't feel that they're able to consent. It's a different issue really in the protecting young people side of it, it's not necessarily whether they meet Fraser guidelines, that's whether there is a risk to them, so that comes under a different [law].[169]

Only one young person involved in the study explicitly referred to Fraser/Gillick guidelines in relation to accessing SRH services.

As mentioned above, while young people knew they were able to access medical treatment/SRH services, the majority did not associate this with having a legal right to do so, and some thought it would be the age of sexual consent which would affect their access to services, rather than mentioning laws around competency. Some young people tended to express confusion or uncertainty about whether and when they would require parental consent before accessing certain SRH services, including some forms of contraception, STI testing, pregnancy testing and abortion, and if so, from what age. This may reflect the earlier point that less specific age-based laws tend to be confusing to young people, who may not appreciate how they apply in practice. However, this did not necessarily appear to put young people off accessing SRH services.

> "I've had young people sit in the clinic with me and they have actually been terrified that they're going to be told off, and they're shaking because they're so scared of their issue and that I'm going to tell their parents. You kind of see it wash over them – that relief – when they start understanding that they're competent to make their own decisions and that they don't have to inform anyone if they don't want to".[170]

4.3 Confidentiality

4.3.1 Young people and access to confidential SRH services: the law

All persons in the UK are entitled to confidential access to SRH treatment, including young people below the age of 16 years, where they are deemed competent to consent to treatment. This is according to principles of confidentiality set out in common law, and privacy rights set out in statutes including the Data Protection Act 1998 and the Human Rights Act 1998. These laws and principles are set out in Guidance issued by the General Medical Council, which provides that: '*Respecting patient confidentiality is an essential part of good care; this applies when the patient is a child or a young person as well as when the patient is an adult*',[171] and that '*The same duties of confidentiality apply when using, sharing or disclosing information about children and young people as about adults*'.[172] The Guidance states that, '*Confidentiality is central to the trust between doctors and patients and an essential part of good care. Without assurances about confidentiality, children and young people, as well as adults, may be reluctant to get medical attention or to give doctors the information they need to provide good care*'.[173] The Department of Health Guidance requires service providers to produce a confidentiality policy reflecting these duties and principles.[174]

However, the law provides that the duty of confidentiality should be broken by healthcare providers where they identify that a young person is at risk of harm or is placing a child at risk of harm. Section 11 of the Children Act 2004 places a duty on a range of organisations and individuals (including healthcare providers) to ensure that their functions and services are discharged having regard to the need to safeguard and promote the welfare of children. Department of Health Guidance states that confidentiality

may be broken '*where a health professional believes that there is a risk to the health safety or welfare of a young person or others which is so serious as to outweigh the young person's right to privacy*'.[175]

On the NHS choices website, advice to young people about access to contraceptives and confidentiality provides that: '*There are strict guidelines for healthcare professionals who work with people under 16 years. If they believe that there's a risk to your safety and welfare, they may decide to tell your parents*'.[176]

The situation differs slightly for health professionals in schools, who would instead by bound by their own school policies.

In Northern Ireland, service providers have mandatory reporting obligations under the Sexual Offences order 2008 of any cases of sexual activity involving children under 13 years old, and for anyone under the age of 16 years old engaging in sexual activity with someone aged above 18 years old.[177] This requires reporting to police, regardless of the particular circumstances in each case.

4.3.2 Research findings: confidentiality and access to SRH services

Young people and service providers across all research locations indicated that confidentiality is essential in ensuring access to services. Though not always conceived as a legal duty or right, young people were generally aware that they had an entitlement to receive confidential advice, information and treatment, though there was some confusion as to the circumstances in which this could be breached. This was seen as being extremely important for facilitating access and removing barriers caused by restrictive social and cultural norms, as described above, particularly barriers caused by stigma and embarrassment.

> What SRH services do you think are most important [for young people]?
>
> **YP:** Anonymous and confidential information outside of school, that won't come back and haunt them.[178]
>
> Do you think there's anything that would make it easier for young people to access (sexual health) services?
>
> **YP:** Maybe if there were things closer in the area, or if the person knew the place was private and confidential and no one would find out who they were speaking to.[179]
>
> A lot of young people are very relieved about the confidentiality policy. They usually have an idea, but when it's the first thing that's discussed, you can see them relax and they'll say "oh, that's good", and you can see it's something that they really value and they may not have known that before.[180]

One of the main barriers to young people accessing SRH services is that they are afraid that the service providers will inform their parents (that they are sexually active). For young people, one of the biggest fears in accessing an SRH clinic is that their parents will find out.

> Some people don't want their parents to know. Some parents won't tolerate it, some won't care, but it's better to keep it between them and you. I think it's a law: if you go to a clinic and give them details and show them your body parts, I think it has to be confidential.[181]

Some young people felt that confidentiality was so important that they were concerned about sexual health information arriving by post where the envelope allowed their parents to identify that it was from a sexual health provider:

> You know when you sign up to clinics and it asks for your address, a lot of people hold back from getting protection because they think, oh, what if it gets sent to my house? Some people I know that are my age won't get contraception if you have to sign up at like Pulse or Brook, I would say.[182]

The young people involved in the focus groups appeared to have a good, though at times, basic understanding of the law relating to confidentiality, including the youngest participants (13 and 14 years). However, as set out above, the law does not provide an absolute right of confidentiality to young people under the age of 16 years. Where service providers suspect that there are child protection concerns, their duty of confidentiality may be breached. Understandings of what this means in practice varied among young people.

> They always stress the importance of what you tell us is between us, unless they feel you're at risk. So having sex doesn't mean you're at risk, unless you're prostituting or something; that would be a big cause for concern, or having sex with a teacher like that thing on the news recently, so things like that would.[183]
>
> There is something that stops a health worker from telling, unless your actions harm yourself or others.[184]
>
> They'd only tell if they were really young, like 11 or something. But if they were 15 then they shouldn't because they're nearly 16.[185]
>
> It should be confidential, even if they're underage, it should be private, unless it's rape.[186]
>
> Depends on how bad it is, or whether you're pregnant[187] [as to whether the health worker would tell anyone that you are sexually active].

Mixed messaging and misinformation provided to young people about the law appears to have made confidentiality and the way that it intersects with child protection obligations difficult to understand in the way that it applies in practice among some young people.

> Young people are given very confusing messages around confidentiality. Some young people under 16, or even under 18, are told they don't have a right to confidentiality. Nobody is told that an under 16 year-old has the same right to confidentiality as somebody over 16, because what's quite often rammed down their throats is safeguarding issues. Now, not every young person has a safeguarding issue, so we can assume that most young people under 16 have the same right to confidentiality as a person over 16. There are obviously procedures for young people who are having sex under the age of 13. So, confidentiality is often misunderstood.[188]

In Northern Ireland, while the significant majority of young people mentioned health care professionals' duty of confidentiality, they were not completely clear on what legal rights were afforded to them, and the majority also thought that confidentiality was age dependent. Quite a few young people thought confidentiality could be legally breached for anyone under the age of 16 who disclosed engaging in sexual activity, even where the activity was consensual, non-exploitative, and non-coercive. They associated the criminalisation of sexual activity below the age of consent with the compromise of their legal right to confidentiality. Many young people also felt it would be right for a doctor to breach confidentiality in the instance of under 14 year olds disclosing sexual activity.

Service providers showed significant concern that the provision for mandatory reporting for under 13 year olds might not always operate in the best interests of the child. It was felt that, in some cases, police or social services' involvement could create negative outcomes, and might negatively impact on whether (and how) young people accessed services.

> What are the specific laws you'd like to see changed?
>
> The sexual offences order could be changed a bit. I think some of it is a bit of a punishment or appears to be, it's very directive around young people… And I agree, under 13s are a particular concern, to have mandatory reporting, there is a concern there and I think professionals should come under strong processes, but if we come across a 12 year old who has engaged in sexual activity and is scared out of their lives, reporting them to social services is not perhaps the best thing. But to actually have a plan of action, not about leaving them, plan of action to work through, but just saying social services is the only route is not the best outcome for the individual. It's back to trying tease out some of those things.
>
> The statutory sector have very straight systems, and we are at the cutting edge of sexual health and trying to marry those two systems; so it's not about someone covering their back, but about what is best for that child.[189]

While young people often thought doctors were allowed to breach confidentiality in the instance of under-age sexual activity being disclosed to them, and some thought that this should be the case as a means of protecting young people from the risks of underage sexual activity, there was also concern expressed that this might affect the likelihood of them then accessing services. Health and Social Care Professionals in Northern Ireland will not reportedly breach confidentiality without a young person's consent apart from in the instance of under 13s, or under 16s engaging in sexual activity with over 18 year olds. However, young people's lack of knowledge of, and confidence in, the law has led to some mistrust of professionals among young people..

Young people living in and around Belfast were aware of Brook and felt they could access this service confidentially, though one person described people waiting in the waiting room as looking as if "*they'd been slut-shamed*",[190] and service providers thought that young people were still worried about being afforded confidentiality, and were conflating the laws relating to confidentiality and the age of consent, as evidenced by their reluctance often to give truthful personal details.

> You mentioned before that the law does provide for confidentiality; do you find that young people's knowledge of that is low?
>
> Yes, to do with GPs, and when we first started, people would give us false names to start with. They've got more confident now…. but they're not confident about age of consent rules either, 'cos they give us false dates of birth, and revoke this when their time at Brook (according to the false date) should expire. After they come in, they find out it's confidential… and we want them to trust us to give us a full picture.[191]

Some young people – particularly those in Northern Ireland – expressed mistrust in service providers, and especially local GPs, as to whether they adhered to laws and guidance on confidentiality. They felt that family doctors may be likely to share their information with adult family members, particularly if they were below the age of sexual consent. They were also concerned that they might be related to, or know, other people working in clinics or doctors' surgeries, who would be similarly likely to share their information with adult family members. These ideas appeared to derive from a lack of knowledge on the law relating to confidentiality, combined with a feeling of, "*everybody knows everybody else and everybody*

else's business", in Northern Ireland. Added into this mix are the cultural, social and religious norms which strongly stigmatize young people's sexuality, leaving them concerned that their confidentiality is unlikely to be respected, since they are engaging in behaviour deemed to be dangerous and morally reprehensible.

> Would [the young person] be likely to seek contraceptives or contraceptive advice from a doctor?
>
> No.
>
> Why?
>
> Fear about telling your mum.
>
> Specially if it's a family doctor.
>
> And they're not supposed to tell but people are still afraid of them doing so.
>
> They're like vigilantes.
>
> Judgemental.[192]
>
> It would depend on whether you were underage and by yourself and had a sex scare or something, and whether they'd have to tell your parents, or if the person treating you or someone who works there know someone; if they're a friend of your dad's.[193]

Other service providers, such as those working within schools, appeared to be subject to different confidentiality procedures and duties, and young people appeared to be unclear about this. These procedures may allow for breach of confidentiality in more circumstances than that prescribed in health guidance, perhaps causing a barrier to access among young people.

> **Service provider:** I think different organisations will work under different policies, school nurses I know are bound by the school policy and there are schools I know that school nurses are obliged to talk to the teacher, or talk to parents, we know that this does happen.
>
> Under what circumstances would they be obliged?
>
> **Service provider:** Say, I've got an example, of a young person needing time off school to attend an abortion clinic and the school nurse rang the parents to say, "your daughter's going to be missing school", so they found out that she was having an abortion. I've heard that story. But we do have school nurses who work here you see, with us, so there are some who are really supportive in schools, and no questions are asked, they see young people. And staff governing bodies – that's the other thing – they really have quite a say in some schools. Probably in a lot of schools, it's understood that there are times people need to talk confidentially, but there are some schools where it's really not confidential.[194]

5 Impact of legal principles in accessing particular services

5.1 Accessing contraception

Young people across all research locations reported that contraception, in particular condoms, were easily available and that there were no significant legal barriers restricting their access. Young people across all research locations consistently mentioned condoms above all other types of contraception, closely followed by oral contraceptives, and then the contraceptive injection. Across all locations, discussions of contraception were frequently limited to condoms, which were perceived, even by the youngest participants (13 and 14 years), to be easily and widely available to young people of all ages from a variety of sources. Some young people mentioned increased difficulty accessing other forms of contraception, which would entail finding a service provider, rather than visiting a shop or chemist.

Condoms are provided for free through some youth centres, schools, student unions, family planning clinics, doctors surgeries and, where the young person is able to pay, from shops or dispensers located in toilets.

> It's easy. Everyone can get them for free – from the youth centre, the c-card from the age of 13, or you can get them in the toilets (from dispensers). You don't need anyone's permission. It doesn't matter how old you are.[195]
>
> Youth groups next to near throw condoms at you as soon as you go in.[196]

In England and Wales, some young people mentioned the c-card scheme, which gives young people access to condoms from pharmacies free of charge between the ages of 13 and 24 years. C-cards can be accessed through a range of providers, including youth groups, schools, pharmacies and GPs.[197]

Emergency contraception was perceived as being easily available through GPs, shops or chemists in England and Wales, though in Northern Ireland it was known to be expensive if accessed in a shop and service providers were keen to see emergency contraception being provided for free in pharmacies, with the age limit on accessing it changed too.

While there were thought to be no significant legal barriers to accessing contraception, there were nonetheless differing perceptions among young people as to whether there is an age below which they need parental consent before accessing contraception, with some young people questioning whether people under 16 years needed the consent of parents of guardians. Particularly with contraception other than condoms, there was a perception among some young people that people below a certain age (usually believed to be 16 years) need parental permission before accessing the contraceptive pill or injection. This confusion could perhaps be attributed to young people conflating the age of consent with laws relating to consent to medical treatment.

> **Do you know if you need someone's permission to get contraceptives at any age?**
>
> **YP1:** I don't think so.
>
> **YP2:** Do you if you're under 16?
>
> **YP3:** I think it might depend on the type of contraception it is.
>
> **YP1:** But they should always ask the young person why if they are underage.
>
> **YP4:** I think for some there is an age for access.
>
> **YP5:** I think it depends on your doctor if you're under 16, but you can have the pill without your parent's consent.[198]

Some young people recognized that confidential access to contraception may be restricted in particular circumstances, or where young people are below a particular age (usually believed to be 13 years).

> **Do you think what age they are would matter, when they try to get contraception?**
>
> Don't think so; not really, unless you're like 13 or something. That's when they might question it more.[199]

There was some confusion among young people, particularly in Northern Ireland, over whether a young person would need parental permission in order to order to access emergency contraception under the age of 16 years. Though no young person referred explicitly to the law on mandatory reporting in Northern Ireland, many suggested that, at 13 years, confidentiality would automatically be breached if trying to access emergency contraception.

While the law was not perceived as imposing a significant barrier on access to contraception, young people referred to other barriers. Some young people reported that it might be embarrassing for them to access contraception, and that this would operate as a barrier in some cases, particularly where condoms needed to be accessed through a shop or chemist, rather than a youth centre or SRH provider. It is very likely that young people who have easy access to youth centres and SRH providers are not impacted as significantly by social norms that make it feel embarrassing or shameful for young people to access contraception.

> If you go to the doctor's I think it doesn't really matter but if you go to Tesco's or something to buy contraception, at the back of your head there's always like, is the check out person

going to give me a funny look because I look under 16, are they going to judge me by what I'm buying?[200]

If I needed anything like the contraceptive pill or anything, you had to go to this only Boots and you risked social embarrassment doing that, you know.[201]

Some service providers spoke of the lesser likelihood of more vulnerable groups accessing sexual health services, including contraception, with higher rates of teenage pregnancy in more deprived areas and lower levels of knowledge on how/where to access services among migrant communities, compounded by language and cultural barriers.

In Northern Ireland, for young people not living near one of two Brook clinics in the country, they would either need to travel to a clinic, having cost implications and creating difficulty in how to make up an excuse to family, or use a local service or visit a local shop – both of which service providers thought young people would be reticent to do, due to confidentiality concerns and worries of "seeing someone they knew." Within a culture traditionally opposed to sex outside of marriage, and strongly opposed to underage sex, young people felt they would (and had been) judged by shop staff and would be highly concerned that someone they know might see them. It was thought that the younger a person was, the increased level of embarrassment they would feel, affecting their likelihood of accessing contraception. This highlights the importance of facilitative laws that ensure confidential access to contraception, as confidentiality helps to remove barriers caused by restrictive social and cultural norms.

Other facilitative laws that ensure quality SRE and access to information more generally also appear to be extremely important in accessing contraception, as this can increase knowledge and awareness of contraception, including why it is important and what different types exist.

I think it's important to be educated on the different types of contraception too, because there is so many and each person should be able to choose the right one for them.[202]

There is a strong focus in Northern Ireland on guarding against teenage pregnancy, with this being heavily emphasised in school education. It appears that this focus impacts on young people's use of contraception. Young women were less likely to protect against STIs if they were on the pill, often only using condoms if they were not, and young people stated the reduced likelihood of people engaging in same-sex sexual activity using protection, since education often focused predominantly on the reproductive side of sexual activity, and pregnancy was not a risk to them.

Would they use contraception?

If they're on the pill they wouldn't use a condom but if not, would use a condom.[203]

Girls were perceived to be more likely to use contraception than boys, being considered by most young people as the one more at risk. This again follows the societal focus on the reproductive side of sexual health, where *"guys don't see it as their responsibility"*,[204] since they cannot get pregnant.

Some young people felt that attitudes towards gay men and lesbian women differed in that gay men have been associated with high risk of HIV, and therefore have been the target of campaigns driving them to use condoms, whereas lesbian women are frequently deemed as not having "real sex" and therefore not needing to use protection. The protection available to them was seen as limited, hard to access and unappealing, and none of the young lesbian women that we spoke to were currently using any form of protection.

5.2 STIs and other sexual health problems

Young people in all locations did not recognize any explicit legal barriers to accessing free sexual health screening or STI testing. However, some young people were unclear about whether confidentiality would be breached if under a certain age and visiting a clinic or GP for testing, showing confusion once again around the implications of the legal age of sexual consent. A few thought that, while they could access sexual health testing and screening services, they might need permission if aged below 16, and 13 was again brought up as an age where doctors might be concerned and therefore contact parents, particularly and perhaps unsurprisingly given the mandatory reporting obligations, in Northern Ireland.

Some young people, while evidently understanding the duty of confidentiality in this context, nonetheless expressed concern that it would be broken.

It doesn't matter how old you are – you can go to the doctor and the doctor won't tell anyone. You don't need permission from anyone. Though I'd be worried the doctor would tell my parents.[205]

Young people were uncertain as to whether they were legally required to disclose having an STI/STD to a partner. Some knew there were laws around HIV, although they were not clear of the details or implications of these. Young people in general thought that they legally should have to tell someone, and some were concerned they would "get done." They were similarly unsure

of whether a doctor was legally allowed or obliged to breach confidentiality in the case of having an STI/STD, with some thinking service providers could tell their partner, and some thinking this was not the case.

This uncertainty around confidentiality and the circumstances in which it could be breached would likely operate as a barrier to access, as young people expressed an acute sense of shame or embarrassment in relation to accessing STI testing in particular: "*You'd just get some people who would go, 'no, I don't want to'; 'I don't want to embarrass myself like that'*."[206]

The majority of young people stated that they would themselves seek medical advice and get checked out if they were experiencing sexual health problems, though many young people reported that they would speak to friends or carry out research online before trying to access a specific health service, and embarrassment was flagged as the primary reason that someone might not access testing. Some young people mentioned the stigma attached to contracting an STI/STD, expressing the view that young people with an STI/STD would be stereotyped as "*a slut, sleaze; someone who's gone around so much that they've caught something*".[207]

The fear of "people finding out" was mentioned by young people as a barrier to them accessing STI/STD testing. Young people were sceptical of the level of confidentiality afforded by local services, especially GPs, and the concern that they might "*bump into someone they know*". Young people thought the fear of finding out they "had something" might also put people off.

This appears to operate as a barrier particularly in more close-knit communities, where fear of people finding out is compounded by lack of provision seen as confidential by young people. In Northern Ireland, most young people thought that testing would be more difficult to access than contraception, especially in more rural areas where provision is lower. Northern Ireland does not have integrated NHS sexual health service provision in most areas, and therefore, sexual health services will not necessarily provide family planning and testing in the same place. This has clearly caused confusion among young people as to where they can access testing, but also, young people felt the opening hours and locations of these services were prohibitive. Young people had more confidence in Brook and GUM clinics for providing confidential sexual health testing, but there are only two Brook clinics across the whole country and often the young people we spoke to did not know of a GUM clinic in their local area. There was confusion about where they could access testing, and they were not sure what tests were available in local chemists or Youth Health Advisory services in colleges. They also discussed the need to travel for over 20 minutes by car to access testing as being a barrier.

Most people outside of Belfast stated their GP as the primary service provider they would use, despite concerns about the level of confidentiality and feelings of embarrassment about using this service, discussed above. Some young people stated that they would have to find somewhere else to access testing, "*'cos you can't go to your doctors to get it done, that's ridiculous*".[208]

> Would there be any reason why a young person might not want to seek advice?
>
> Distance?
>
> Yeah.
>
> I do think there should be more places around offering certain services, but it kind of boils down to the person, I think they should have a few more confidentiality processes so the person feels more safe and secure to sit there and have a chat about their body.[209]

SRE was also highlighted as important in reducing barriers to accessing STI/STD testing. In Northern Ireland, while most young people had received education on STIs/STDs, sex education and society in general seem to place increased focus on the reproductive side of sexuality. This played out in young people's responses to questioning around unprotected sex, where risk of pregnancy was the first, and in most cases the only, concern mentioned unprompted by the young people we spoke to. Once prompted, they were knowledgeable and felt someone should go and get checked if experiencing a sexual health problem, though they felt that, in reality, motivation to do so might be dependent upon who they had slept with and how promiscuous they believed that person to be.

Sexual orientation impacted strongly on the likelihood of accessing sexual health testing. The lesbian young women we spoke to felt that society did not view them as engaging in "real sex", and therefore did not think they needed sexual health check-ups. One lesbian girl in Northern Ireland that was involved in the study listed her previous female sexual partners to a service provider (upon request), but then was subsequently recorded on the computer record system as "not being sexually active". Regardless of differing risks associated with different types of sexual activity, this societal attitude is likely to negatively influence young lesbian women in accessing services, and appears to be rejecting the existence of their sexuality.

Conversely, young gay men in Northern Ireland were reportedly viewed as very sexual, and often as promiscuous. There is a current drive towards addressing rising rates of HIV in the jurisdiction, by targeting gay men with strong HIV messaging. Some young people felt that there was unfairly weighted focus on the spread of HIV among gay men, with scare tactics often employed. Awareness of HIV testing on this issue was therefore high among this group; however, there was a more limited focus on the risk of contracting other STIs/STDs.

5.3 Pregnancy testing and care

Young people across all locations did not perceive any explicit legal barriers to pregnancy testing, and most were of the view, generally, that they could buy a pregnancy test at any age, and could get one for free from their GP. However, for young people reticent to visit the GP, cost can be a barrier, with some young people reporting that they would be unable to afford to buy a pregnancy test.

> You can buy a pregnancy test, but this is expensive, so you can go to the doctor and get tested for free. The doctor has to keep it a secret. Going to the doctors is really scary though.[210]

Cultural, social and religious norms that stigmatize young people's sexuality appeared to play a more significant role in access to pregnancy testing than the law. Some service providers expressed the view that, in light of the social stigma attached to teenage pregnancy, the duty of confidentiality is especially important in ensuring that young people who are pregnant or want to be tested for pregnancy can access an SRH service, and that young people are misinformed of the law in this respect. They reported that young people are concerned that if they access a service provider in relation to a pregnancy and are under 16 years, it means that the service provider will automatically break confidentiality. They do not tend to know about the duty of confidentiality properly until it is explained to them by the service provider: "*If there was clarity, it would remove that barrier to accessing the service in the first place*".[211]

In schools, it was reported that school nurses tend to tell the parents of a young person's pregnancy (most schools have a policy that they will break confidentiality if there is any sexual activity, especially in the event of a pregnancy).[212] It was reported that, when a young person believes they are pregnant, they fear telling their parents, and confidential access to pregnancy testing, advice and counselling is essential.

Young people in Northern Ireland asserted that most of them would not go to a doctor until they were sure they were pregnant, as they would be concerned about confidentiality/bumping into someone they know and people unnecessarily finding out they had been having sex. This fear of exposure (in part due to lack of trust in confidentiality protocols) and predicted negative reaction by family and wider society may be causing young people to delay or completely avoid accessing the services and advice they need. For example, the research revealed stories of people hiding pregnancies (one relating to someone of 29 years old) due to fear of stigma attached to those having sex outside of marriage/long term relationships.

There were perceived to be no direct legal barriers affecting young people's access to prenatal and antenatal care, and young people in all locations felt their access to health services before and after giving birth would be good, some feeling that they would get increased access to services the younger they were. A group of young mothers in Cardiff mentioned that they had received good access to information and support on the NHS, and that there is no age limit to receiving antenatal care – young people can even get it from age of 13 years, if required.[213]

In Northern Ireland, social and religious norms appear to be operating to restrict a young person's options in relation to pregnancy and parenting. The vast majority of the young people involved in the research in Northern Ireland reported instances relating to someone they knew having a baby at a young age, though simultaneously, young people felt that society would react negatively to a girl under 16 having a baby.

The law and social welfare system in Northern Ireland appears supportive of young mothers and abortion is illegal and strongly stigmatized. However, young people felt that someone who had a baby at a young age or gave up a child for adoption would also be stigmatized and would regret their choice. This negative attitude towards young pregnancy was linked by some young people with social, religious and cultural norms, which disapprove of sexual activity outside of marriage or long-term relationships. While younger generations generally did not demonstrate such strict views against sex outside of marriage, they nonetheless still felt that a girl would be judged negatively by her family, school, peers and friends if she became pregnant outside of a long-term or solid relationship. A few of the young people we spoke with also viewed this type of activity as "promiscuous" and therefore negative.

> It depends how she got pregnant. If she got pregnant through being a slut then obviously they're going to judge her, but if she got pregnant 'cos she's in a relationship and she's having a baby and he's gonna stick around then I think people nowadays would be alright with it.[214]

Young people felt that teenage mothers were being judged less harshly than in previous times, but negative attitudes still prevailed about young single mothers.

> I couldn't go, "Well you're a slut," 'cos some teen mums have been with their boyfriends for years.[215]

Young single mothers of previous generations would have been strongly pressured or forced to give up their child for adoption, and while young people feel this is no longer the norm, there is still a culture of shame around being young, single and pregnant, and young girls are often pressured by parents to have the child adopted, or have an abortion.

Most young people reported that they would not tell their families until they were sure they were pregnant, and most felt that parents would react with anger and disappointment at first, before becoming supportive later on. As mentioned, there was concern that parents might try and take the decision away from their daughter – with young people feeling this would likely involve a push towards adoption or abortion, the pressure increasing the younger the person was. One group told of being taught in school about the dangers of being pressured into having an abortion or adoption by family, and how to resist such pressure, though this does not seem to be consistent with the prevailing stigma attached to both adoption and abortion. In discussion with service providers, it was felt that parents often held these views up until the point where their own daughter was pregnant, at which point they would be less against adoption or abortion.

5.4 Access to abortion

Access to abortion represents the area in which there is the starkest variation among laws in England/Wales and Northern Ireland. In England and Wales, the same legal principles of consent and confidentiality apply where a young person wishes to access an abortion, allowing a young person to have an abortion, in confidence, where they are assessed to have the mental capacity to consent to the treatment. However, there are additional conditions imposed by law that must be fulfilled before a young person may access an abortion. According to the Abortion Act 1967, a woman (including a young woman) must ensure that two doctors agree that an abortion would cause less damage to a woman's physical or mental health than continuing with the pregnancy.[217] Also, an abortion cannot be carried out where the pregnancy exceeds 24 weeks.[218]

The Abortion Act 1967 has a conscientious objection clause[219] which permits a doctor to refuse to participate in a termination if he or she has a conscientious objection to performing an abortion, but which obliges the doctor to provide necessary treatment in an emergency when the woman's life may be jeopardised.

The Abortion Act 1967, which covers the rest of the UK, does not extend to Northern Ireland, and women from Northern Ireland are not entitled to abortions for free on the NHS in England. The legislation operating in Northern Ireland on abortion is included in sections 58 and 59 of the Offences against the Person Act 1861 and sections 25 and 26 of the Criminal Justice Act 1945. These provisions apply, in effect, to make abortion illegal to procure or perform, in all circumstances, except where it is done '*in good faith…to preserve the life of the mother.*'

> "The fact of the matter is, when you make it against the law, you don't stop it, you don't even reduce it, you just make it so that women with money have options and women without money have babies – or do crazy, desperate things".[216]

5.4.1 England and Wales

Young people and service providers in England and Wales reported that the legal framework on access to abortion did not create any significant barriers, and that, in most cases, young people are able to access an abortion confidentially, and (on the NHS), for free. However, it was felt that the impact of the additional legal restrictions on access to abortion in the UK could operate as a barrier to access in some cases.

> We have a legal limit on abortion at 24 weeks. We need two different doctors who need to sign off on it, these kinds of barriers… I don't think they are big issues, but for a young person who doesn't know what they want to do, needs time to make a decision or isn't aware that they are pregnant… it's something that I worry about… I imagine it can be very distressing for someone.[220]

Also, some service providers appear to be imposing additional restrictions on access to abortion for under 16s, making it difficult for them to access an abortion confidentially. Some abortion providers will only accept people who have already undergone counselling (rather than providing it in-house), and some service providers will not treat under 16s unless they are accompanied by an adult (e.g. parent, elder sibling etc.).[221]

> There are some centres that want under 16s to be accompanied by an adult….there was one centre who said they wanted someone to be accompanied by an adult if they're under 16, but I think that's changed slightly…in some areas, two doctor's signatures are required to access an abortion, but this is sometimes facilitated by the abortion service provider themselves…[for some time] there wasn't a centre in Manchester who would see a young person beyond 20 weeks, so they would have to travel to another city in these cases.[222]

Also, some young people expressed the view that, legally, they would need to get their parent's permission to access an abortion if they are under 16 years. Access without parental consent and confidentiality is acutely important for some young people who

may have a well founded fear of being killed by their parents should their parents find out,[223] so these additional restrictions would operate as very significant barriers in some cases.

Young people who need confidential access to an abortion are reportedly impacted by other barriers, including the practicalities of accessing an abortion without parents finding out. Some young people will need to mask the clinical side effects and psychological impacts following surgery so their parents will not detect that they have had an abortion: "*some young women have an abortion and have to go home and get through the night pretending to have a stomach ache*".[224]

5.4.2 Northern Ireland

Young people were clear that abortion is illegal in Northern Ireland, apart from in the most exceptional cases, but were less clear about the circumstances under which someone could access an abortion. A small number thought it was legal in cases of rape, and also that it should be. However, most others knew that this was not the case, and they agreed with the law prohibiting this.

> **YP1:** I don't think abortion should be allowed at all.
>
> **YP2:** Unless it's rape.
>
> **YP1:** Even if it's rape I don't think it should – give it up for adoption. But abortion no, that's just killing a life.[225]

Only a small number referred to early medical abortions, though were not clear on the number of weeks these were available within. Many had never heard of medical abortions. Young people were also not clear on whether they were legally allowed to seek abortion in England, and felt this might be age dependent (one group asserting that it is prohibited for under 16s to travel overseas alone) or might be restricted on similar grounds to abortion in Northern Ireland.

Doctors in Northern Ireland are permitted to refuse to give information or services on abortion on religious and moral grounds, and in instances where a doctor who does not agree with abortion is approached, they are required to signpost a patient on to a service they can use. Service providers expressed concern that this does not always happen in practice, and many young people were under the impression that, due to the illegal status of abortion, they would not be able to seek advice from a doctor. Some thought doctors were not legally allowed to provide information, while others felt most doctors simply would refuse on personal grounds to give advice. Service providers felt that knowledge among professionals and in the media was low, impacting negatively on young people's access to information.

In addition to being legally restrictive, the two prominent religious communities in Northern Ireland are reportedly both strongly opposed to abortion, and the number of people who identify as non-faith are in the extreme minority. Every young person we spoke to was opposed to abortion and service providers felt this was unsurprising, given that the society, schools and families young people grow up in are predominantly anti-choice and underpinned by faith-based moral values. Young people couched their views in consistently similar terms, expressing that abortion for any reason was killing a life, and that regardless of the circumstances, the girl should give the baby up for adoption if she could not keep it, rather than having an abortion.

The prevailing stigma attached to underage sex, sex outside of marriage or a relationship, and the taboo on discussing sexual activity for non-reproductive purposes may explain young people's conceptualisation of young pregnancy in terms of "sluttish" behaviour. Many young people expressed that girls should not be allowed an abortion just because they wanted one, or just because they had "been silly". Young women being forced (through lack of other options) to follow through with a pregnancy appeared to be viewed by some as a deserved consequence – or punishment even – for engaging in "promiscuous" behaviour.

> **Is that an option for your peers?**
>
> I don't know, I don't think that anyone should be forced to have a child, but then on the other hand it's her fault for doing it, but if they're just going to be born into not a good home, it sounds bad but…in some ways I do agree with it, like if the girl's been taken advantage of or raped she should be allowed to, but if it was her being silly, then it probably shouldn't be as easy, she'll just have to deal with the consequences.[226]
>
> **And where do you think most people's views come from?**
>
> Religion, religion believes abortion is a sin.[227]

The legal framework, which can be seen both as a product of and as informing social norms and religious values, creates a very restrictive environment for young people attempting to access an abortion.

When asked what a girl's options would be if she became pregnant, the majority of young people mentioned abortion, though with the caveat that it was illegal in Northern Ireland and they would have to travel to England. Those that did not mention it knew of this option upon prompting, but when asking everyone whether it was a real option for young girls in Northern Ireland, young people felt that the majority of people were against abortion and therefore would not seek it.

Girls and women in Northern Ireland can and do travel to England to procure an abortion, and there is a specific not-for-profit

provider that assists women in doing so. There are believed to be around 4,000 women who travel to England every year in order to procure an abortion.[228] Women may also access an "early medical abortion" online, with one organisation operating a website from which women can request RU486 to be posted to them. However, the use of RU486 is only approved to nine weeks into a pregnancy, so this will not be an option for some young women.

> Often, the younger girls tend to be later term. You know, first you have to figure out you're pregnant, then you have to figure out whether you can tell mum and dad, and then you have to figure out how to come up with £450.[229]

It is very likely that young women, and particularly those from strongly conservative and / or deprived backgrounds, will be more heavily impacted by the restrictive legal framework on abortion in Northern Ireland. Young people may lack independent means to travel to England and may be unable to explain their absence to parents and peers easily; restricting their access to abortion.

> One of the patients still haunts me, she was an 18 year old girl who was a Traveller and she said "I can't have this baby. I don't know what to do. If my parents found out that I had sex, they would kill me – I'm not kidding." And she's not kidding, they will kill her. And then we couldn't get in touch with her again.[230]

Some young people and service providers participating in the study mentioned instances of young people drinking alcohol, taking narcotics or drinking cleaning chemicals as a method of incurring a miscarriage – though they felt this was less common than in the past.

Service providers confirmed that an extremely small number of young people contacted them having decided they wanted an abortion, although of course, the number of young girls accessing medical abortions over the internet is unknown. For young women accessing online medical abortions, the restrictive legal framework appears to have a negative impact on their subsequent access to treatment. Service providers reported that where these young women needed medical attention, they were often afraid of admitting they had taken RU486 for fear of being charged with procuring an illegal abortion, thus endangering their health further.

Everyone we spoke to thought that someone would be judged negatively for having an abortion, though we only heard one story directly corroborating this – a story of a girl who accessed abortion in England and was subsequently bullied at school.

> There was a girl in my school who had an abortion. She didn't tell people she was pregnant, but everyone knew; she used to sit and rub her bump, and then a month later it was gone and she wouldn't admit having an abortion.
>
> How did her peers react?
>
> Everyone took it bad, 'cos she didn't tell the grandparents or the daddy, so everyone took it bad.[231]

Young people and service providers felt that society has become more open to abortion and, though still perceiving it to be wrong in the majority of circumstances, are becoming more open to allowing it in instances of rape or incest.

Service providers mentioned that, while the anti-choice groups are vocal, they are also fairly small. However, politicians were described as still being "scared" to discuss the topic and, while the law is not creating a significant barrier to access for older, more well-off women, the law and entrenched stigma have created a real barrier against access for young people and those from less wealthy backgrounds. Young people themselves expressed that there were often negative consequences from having a baby at a young age, but for most young people this would be the only option other than adoption, which is also stigmatized.

5.5 Treatment for gender reassignment

Young people can legally access medical assistance to help transition to their preferred gender identity. While there are no explicit legal barriers to accessing these services, the NHS guidelines do provide several age-based restrictions on accessing services, such as hormone therapy and gender confirmation surgery. Young people are not permitted to access hormone therapy before the onset of puberty. When they have reached puberty, they may access hormone-suppressants. Children cannot access cross-sex hormone therapy until they have reached 16 years of age and have been taking hormone suppressants for several years. These restrictions may have a negative impact on young people. The Endocrine Society[232] and WPATH[233] advocate that puberty suppressant treatment be made available to young people in the early stages of puberty, since it can be psychologically and physically beneficial.[234] Allowing access to drugs such as GnRH, which slow or halt the physical developments of puberty, has a number of advantages,[235] including: alleviating the distress caused by the physical development of an assigned gender in opposition to a young person's identified gender; prolonging the period during which a child/adolescent can explore their gender identity before their body begins to change; reducing the need for traumatic and invasive forms of sexual reassignment surgery in later life;[236] and lastly, preventing young people from seeking these drugs illicitly if denied access to them. Young people will not be able to make an application to change their gender legally until they are at least 18 years old.[237]

Service providers appear to impose their own restrictions on young people attempting to access medical transitioning. According to service providers, some services will support young

people to transition from a young age, but others will refuse to deal with a person until they reach 18 years.[238]

> They told me I couldn't have hormonal therapy until I was 18. It's just their policy. So I begged. In the end I had my first appointment one month before I was 18.[239]

There are limited specialist services for transgendered young people in the UK, with one sexual health clinic for transgendered persons in London and another in Belfast, placing significant limitations on access. Services could be accessed through non-specialist service providers; however, the trans-identified young people involved in the study reported that mainstream services lacked awareness of transgender identities and did not have sufficient services or training to accommodate their needs. This was a position supported by service providers involved in the study.

6 Discrimination and legal recognition of diverse sexualities and gender identities

It is important for the law to enable all young people to access SRH services, regardless of their race, religion, sexual orientation, gender identity, disability or any other identity characteristic. This will help facilitate access directly as it will prohibit a service provider from refusing to give services to young people with particular characteristics, and give them legal standing to challenge decisions to refuse services on particular grounds. It can also provide an imperative for government to ensure that services are available to meet the needs of all young people. Lack of legal recognition and protection can have the reverse effect: it may mean that the needs of particular groups of young people will be excluded or marginalised within mainstream service provision.

In the UK, the Equality Act 2010 prohibits discrimination against persons according to several 'protected characteristics'. According to this Act, discrimination includes both direct and indirect discrimination. Direct discrimination is the treatment of a person less favourably on the ground of a protected characteristic,[240] and indirect discrimination is the application of a particular provision or criterion that is discriminatory in effect as it would place a person with a protected characteristic at a particular disadvantage.[241] Protected characteristics include, among others, 'sexual orientation' and 'gender reassignment'.[242] These terms are further defined in the Act. 'Sexual orientation' is defined quite broadly and encompasses a person's sexual orientation to the same sex, the opposite sex, and either sexes. 'Gender reassignment' includes a person who is '*proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex*'.[243] Persons who do not identify as male or female, such as persons who are third gender, genderqueer or intersex, are not explicitly legally protected in UK equality law.

The law in Northern Ireland relating to gender identity and sexual orientation differs from the rest of the UK: equality law in Northern Ireland only protects LGBT people and people having undergone gender reassignment from discrimination in employment and the provision or services, and not, significantly, in schools. Also, gay couples are not permitted to adopt children, and gay men are not permitted to give blood.

6.1 (Lack of) legal recognition of non-binary gender identities

While the Equality Act 2010 (England/Wales) and the Sex Discrimination (Northern Ireland) Order 1976 prohibit discrimination on the ground of 'gender reassignment', this is limited to persons who are proposing to, undergoing, or have undergone sex reassignment. This still requires persons to identify as male or female. It does not protect persons who do not conform to gender-binary identities, for instance persons who are third gender, genderqueer or intersex.

> "A young person who identifies as transgender, genderqueer, third gender or intersex, where they access a medical clinic, they are automatically identified as having a disorder. It is changing though…"[244]

> People who are third gender have no legal protection the way transgender people do. Whatever minimal protection transgendered people have is not offered to people of third gender. This is an omission from the Equality Act.[245]

Lack of legal recognition and protection of third-gender, genderqueer and intersex people can create structural barriers for young people who do not identify in a gender-binary way, as the law provides no imperative for providers to ensure that services are available for these persons. It also does not provide young people with legal recourse where existing services are withheld from them on the basis of their gender identity.

In practice, this can have the effect of denying transgender, genderqueer and third gender young people from accessing particular SRH services that they require. Transgender, genderqueer and third gender young people require both information and services that all young people need, and may also require specialised services. This can include access to specific types of contraception, hormone therapy, and advice around using hormone therapies (for instance, that it can affect contraception and antiretroviral drugs etc.). Some gender reassignment surgery can leave (young) people exposed to STIs, and they may need specialist advice on this. Awareness of these issues among non-specialist service providers was reported to be low.[246]

Lack of legal recognition can also reinforce gender-binaries within mainstream health providers. It is NHS policy and practice in mainstream services of only recognising 'male' and 'female' identities, for instance. This can create a barrier for young people who try to access these services and do not fit into either identity category, as they may feel excluded from these services, which do not recognize their gender identity.[247]

In Northern Ireland, services are often segregated into male and female, thus leaving young transgender, genderqueer or third gender people feeling awkward and unsure of which service to use. While one young man shared a positive experience with a service provider at Brook, whose knowledge of trans issues was low but

whose attitude was affirming and supportive, most opinions were that services would not be so accessible and supportive.

Mainstream SRH services were perceived by many LGBTI young people who participated in the study as being hetero-normative, and gender-binary. This can operate as a barrier by making LGBTI young people feel excluded from the service.

> I went to my GP and she said she couldn't do anything. I thought – yeh right you're obviously lying. I think she didn't know what to do and wanted me to be someone else's problem. I went again to another GP. And she said "ok yeh what do you want me to do". I'd heard loads of stories from others who went to their GP and their GP kept fobbing them off, saying "come back in a week", "come back in a month" or whatever. So I wrote a list of things and gave it to my doctor saying "these are the things you need to do, these are the people you need to contact".[248]

Some young people involved in the study reported that, due to the lack of awareness and recognition of third gender, genderqueer and transgender young people among mainstream health providers, they preferred to use a specialist health provider.

> It's best to be in the transgender community sexual health advice, to discuss sex with someone who is trans-friendly. There is nothing out there in the mainstream.[249]

> There is now a place called CliniQ, which was specifically set up for transgender people and their allies, for instance, a person who identifies as a male can go in there, tick 'male' and ask for a pregnancy test. They go and get a pregnancy test and there would be no raised eyebrows or anything, whereas if that transgender person went to a mainstream place or to their doctor, ticked 'male' and asked for a pregnancy test, there have been times when their gender would be changed to 'female', or you know, there has been a lot of ignorance and lack of awareness around the sort of trans-identity and how that correlates to sexual health matters.[250]

There are some organisations (including the NHS) providing mental health services for transgender young people, however, there is only one medical service in the UK which specialises in helping children with gender disphoria. The Tavistock and Portman NHS Foundation Trust is the only place currently providing hormone treatment for children and young people under 16 years old. This will be out of reach for many young people, who will have to rely on mainstream service providers.

6.2 Discrimination in schools against LGBTI young people

Homophobic and transphobic discrimination and bullying in schools can impede a young person's access to SRH services by intimidating young people and creating an environment in which it is difficult for them to be out and open about their sexuality and gender identity. In Northern Ireland, legal protection against discrimination on the grounds of sexuality and gender reassignment does not extend to schools. This denies young people legal recourse when they are being discriminated against, and it provides no legal imperative for schools to actively address and prevent homophobia and transphobia.

High levels of bullying, discrimination and homophobic attacks were reported both in schools and outside in town centres and in clubs in Northern Ireland. Schools appear to be responding only to physical aspects of fights or bullying, rather than addressing root causes of discrimination. Students reported being told that the school could not do anything in response to a homophobic attack, but that if the pupil took the fight off school grounds, then they could report it to police as a hate crime. LGBTI young people were very clear that they were unlikely to report bullying as a hate crime, and felt strongly that it should be covered in equalities legislation.

> Law doesn't force teachers to protect children specifically on grounds of homophobia.[251]

> If you report it as LGBT in the school the school won't do anything about it, they don't have to, if young people want to be taken seriously they have to report it as a hate crime to the police.[252]

In England and Wales, while the Equality Act 2010 prohibits discrimination on the grounds of sexual orientation and also provides protection to transgendered young people in schools, LGBTI young people and other young people participating in the research reported incidents of bullying of LGBTI young people in schools by other students. This particularly appeared to affect young gay men, thus indicating that social pressures restricting expressions of sexuality that do not conform to the heterosexual norm are deeply entrenched within schools.

> There are loads of lesbians at my school and no one cares about it. But if someone came out and said they were gay, they would get it at my school. They would definitely be bullied.[254]

> If someone at our school was gay, they'd get beaten up.[255]

> **YP:** If I was gay, I wouldn't tell anyone I don't think, 'cos I know the way people would go about it.

> "All gay people are picked on in schools. If racism happens, it's jumped on and dealt with really quickly, but if homophobia happens, it's ignored".[253]

> How would they react?
>
> **YP:** I'd probably have no friends by the end of the day.
>
> Why's that?
>
> **YP:** It's just the way people are, the way my friends are in these areas. They don't really like gay people. I don't see anything what's wrong with it but.[256]

However, some young people reported that LGBTI young people were becoming more accepted in schools.

> **YP 1:** I have noticed a massive change. It has significantly got better.
>
> **YP 2:** I don't think young people mind. It's very common these days.
>
> **YP 1:** It's more accepted.[257]

Young people also perceived a lack of action on the part of schools to address homophobia, in contrast to other protected identity characteristics:

> In my school, the words "fag" and "gay" are used all the time and no one does anything about it. If someone used the word "nigger", the reaction would be totally different.[258]

Very concerningly, one transgendered young person reported being raped by a student, following having experienced bullying by the same student, which was linked to his gender identity. He reported the rape to the school (a Head of House), who said that he had fabricated the incident and that he had no evidence, and the matter was not taken any further. He chose not to report the matter to the police, in part, due to the school's response: "I thought that if the school were unsupportive of me, what are the police going to do about it? I didn't really trust them".[259]

Structural discrimination against third gender, genderqueer and intersex young people was also reported, as it was reported that gender-binaries are entrenched within educational institutions.

> Gender is rigidly enforced in schools, much to the detriment of young people. Schools don't allow young people to identify in a non-gender binary way.[260]

> I'm transgender and I'm at an all girls' school, which is difficult. I told the school and had a meeting with my teacher. It was really hard and I was being bullied by other kids. Now they will change my name on the register, but at first I thought they were going to throw me out of the school. My mother was supportive in the meeting with the teacher. They will change my name, but they won't change the pronoun they use for me.[261]

7 Sexual violence, the law and access to services

7.1 Sexual violence and the law

Laws relating to sexual violence can impact indirectly on access to services. Where laws are restrictive or non-comprehensive, young people may be denied support when they seek assistance following sexual violence being perpetrated against them. In addition, a restrictive or incomplete legal framework relating to sexual violence does not facilitate effective service provision for survivors of violence: where the law does not recognize a particular act as an offence, it is unlikely that services will be developed and available for young people exposed to the act.

The law in both England/Wales and Northern Ireland provides comprehensive protection against sexual violence to children, young people and adults. The Sexual Offences Act 2003 and the Sexual Offences (Northern Ireland) Order 2008 both contain a wide range of sexual offences, including rape, assault, sexual assault and causing a person to engage in sexual activity without consent.[263] These offences have 'consent' as their core element, in that the offence will be found to have been committed where there is an act (e.g. penetration) intentionally committed and a lack of consent on the part of the victim. According to both laws, a person will be deemed to consent "*if he agrees by choice, and has the freedom and capacity to make that choice*".[264] Other elements, such as use of force or coercion, are not necessary in order for the offence to be found to have been committed, providing a good level of protection to victims.

As noted above, children below the age of 16 years will be deemed, both in England/Wales and Northern Ireland, to be unable to consent, in law, to sexual activity. In relation to children under 13 years, an offence will be committed regardless of whether the defendant genuinely believed the victim to be over the age of 13 years. Where the offender–victim relationship is one of trust (e.g. the defendant is a teacher or other professional in a position of trust), sexual relations with a child under 18 years will amount to an offence under both laws.

Both laws also contain a wide range of other sexual offences against children, such as incest, grooming, causing children to watch sexual acts, and arranging or facilitating a sexual offence against a child.[265] Penalties for these offences vary in severity according to the age of the child, and some offences apply to children under 16 years, or under 18 years where they are in a position of trust with the offender.

7.2 Impact of the law on access to services

The law in the UK does not appear to be operating as a barrier to young people who have experienced sexual violence accessing services; however, lack of enforcement of the law and social norms that attribute blame to victims in some circumstances appear to limit access to SRH services.

> "Not everyone has sex for the first time because they want to, and that can be hard for some young people, like if they had to say that to a doctor or something".[262]

Most young people involved in the research understood the concept of consent and recognized sex without consent as rape, though some defined it as "sex by force", and many young people in Northern Ireland participating in the study did not demonstrate a good, applied knowledge of consent.

Most young people recognized that an adult having sex with a child is an offence, regardless of consent (though there were some differing views about what the age of consent is, as examined above), and most understood that an adult having sexual relations with a child or young person where they are in a position of trust is unlawful. When asked about the legality and morality of a teacher having a sexual relationship with a pupil, almost all young people considered this morally reprehensible, and many recognized that it is unlawful where the child is 'under age'. Young people almost universally held the teacher accountable for this. Young people felt that the teacher's duty of care made the severity of the crime worse, both in terms of legal consequences, and in a moral sense.

> I think, regardless of your age, if you're in school and you're under the care of teachers, whether you finish school and he's still your teacher, I don't think, I don't know, 'cos there's a teacher-student boundary, like that's how I see it. If you're a teacher, you're a teacher… it's not acceptable at all.[266]

Though, worryingly, a small number of young people perceived that, in some circumstances, the student could be seen as "leading the teacher on", and, particularly for a male teacher, it was seen as a natural impulse in this circumstance, to instigate a sexual relationship. In Northern Ireland, a significant number of young people felt that the student should also shoulder some of the responsibility. The young people we spoke to interpreted the hypothetical situation of a student–teacher sexual relationship to be referring to a young girl and male teacher, and some expressed the opinion that she is old enough (at 15) to know right from wrong. As one young man said, she should know that "there's a line you shouldn't cross behaviour-wise".[267] The fact that she was thought to be 15 years old and unable to consent in legal terms, did not outweigh for some the view that, if you engage in sexual activity, you must automatically be partially to blame. As mentioned above, young people's knowledge on the general laws relating

to sexual violence in Northern Ireland were good; however, they were not quick to identify cases of rape, and neither were they knowledgeable of the legal position regarding young people's ability to consent when under 16 years old. This may be one of the factors influencing some young people's tendency to apportion elements of blame to the victim in cases of sexual violence, since they are not fully cognisant of the implications of legal consent.

While the law in the UK provides comprehensive protection to young people from sexual violence, the research nonetheless identified barriers to young people accessing SRH and other services following an act of sexual violence. Some young people mentioned a sense of embarrassment on the part of the young person and concern for how people might react to her reporting an incidence of violence, and seeking assistance or services. Girls, in particular, may fear being negatively judged, disbelieved or made to feel like they are to blame for sexual violence, and this may prevent them from seeking access to services: *"Teachers or police might not believe her, or she might be afraid of it getting round school"*.[268] Again, ideas around sexual responsibility in Northern Ireland do not seem to coincide with knowledge of the law relating to sexual consent, perhaps due to lack of clarity around the term 'consent' itself, which only one group seemed knowledgeable on. This may be the reason young people felt the likelihood of that person seeking help was lessened: due to fears of being negatively judged.

Some service providers also mentioned the very low rate of conviction in sexual offences cases as a barrier to young people seeking access to services: *"The low rate of rape prosecutions makes some young people unlikely to report rape. They think, 'What's the point?'"*[269] Low prosecution rates for sexual offences and the negative treatment of young victims of sexual violence within the criminal justice system in the UK are well documented.[270] Where criminal laws are known to be difficult to implement in practice, it follows that this would create a significant barrier to young people reporting acts of sexual violence and seeking services.

Lack of knowledge or awareness of what amounts to sexual violence or sexual offences can also create a barrier to access. Some service providers expressed concern that people are becoming sexualised from a much younger age, attributing this to exposure to sexual content in the mass media. They mentioned cases of inappropriate touching from a very young age, and publication of sexual photographs online following a young person 'sexting' their partner, as examples of young people not understanding sexual violence and the illegality of particular acts.

8 Conclusions and recommendations for legal reform

8.1 Overarching conclusions

The UK was selected as a case study on the basis of it being a relatively facilitative legal environment, with few barriers to young people accessing SRH services. There is an absence of explicit direct legal barriers that restrict access to SRH services in the UK, with the exception of laws relating to abortion in Northern Ireland. Nonetheless, the research found that a number of laws operate to impose indirect barriers on young people's access. These barriers are created not only by laws themselves, but also by misunderstanding of laws among young people. Facilitative laws, such as those relating to sex and relationships education in schools, confidentiality and equality laws, assist in facilitating access to services, but some, most notably, laws relating to sex and relationships education, are insufficient and could be strengthened to further promote access to services.

It should be stressed, however, that many other barriers were found to be impacting negatively on access, including, in particular, restrictive social norms that stigmatize sex among young people and among particular groups of young people, including girls. In the UK, these barriers, in many contexts, were seen to be more significant than barriers created by law. However, it is difficult to determine, in practice, the relative significance of indirect laws in light of other barriers. Social, economic, religious and cultural norms that operate as barriers to access are inextricably linked to law, and some of the barriers can be seen as being informed by laws and constructed by the absence of legal frameworks.

The most significant **direct barrier** impacting on access for young people is the restrictive law on abortion in Northern Ireland, which restricts access to abortion in almost all circumstances, including where the pregnancy is the result of rape. While many young women can and do travel to England to access an abortion, the cost and time away from home that this involves is prohibitive for many young people to access independently and confidentially; confidential access being of paramount importance in the context of very restrictive social and religious norms that deeply stigmatize abortion and sex outside marriage and long-term relationships. The law on abortion therefore impacts more significantly on young women from particularly conservative and / or deprived backgrounds, leaving many in desperate situations. The law in England and Wales also places direct barriers on young people's access to abortion by requiring that two doctors agree that the abortion would cause less damage to the woman's mental or physical health than continuing with the pregnancy, and requiring that an abortion be carried out within 24 weeks; though of course, these barriers are much less significant than the heavily restrictive legal framework operating in Northern Ireland, and do not appear to operate as a significant barrier to access in practice.

The law on consent to treatment for young people (the 'Gillick' competency principles) is also a direct barrier. Service providers appear consistently and routinely to carry out competency assessments before providing services, though only very rarely will a competency assessment result in a young person being denied access to services in practice. Nonetheless, it does appear that this principle may restrict young people's access to services. Because the law on consent to medical treatment is unclear and does not specify an explicit age above which young people can access treatment without parental consent, young people appear to be confused about how this principle applies in practice. While young people involved in the research knew they were able to access medical treatment/SRH services, the majority did not associate this with having legal right to do so, and some thought it would be the age of sexual consent which would affect their access to services, rather than laws relating to competency to consent to treatment.

In addition, Government bodies and some service providers appear to impose their own direct barriers to young people accessing services; barriers that are more restrictive than relevant laws. Some service providers in England and Wales impose additional requirements on young people accessing abortion, for instance, requiring that the young people be accompanied by an adult in order to access abortion. This may be symptomatic of abortion not being conceptualised as an unconditional right in law in England/Wales; allowing service providers to impose requirements above what the law requires. Similarly, access to gender reassignment services are restricted not by law, but by NHS guidelines, which impose age-based restrictions on access to particular treatments.

A range of other laws appear to be having an **indirect impact** on access to SRH services by young people. The law criminalising sexual activity with young people under the age of 16 years (the age of consent) appears to be an indirect barrier to access to services. The age of consent law does not appear to be acting as a direct barrier to accessing SRH services in the sense that young people do not fear prosecution for disclosing to a service provider that they have been engaging in sexual activity with a partner below the age of 16 years. However, knowledge of the law on the criminalisation of sexual activity below the age of consent appears to have an effect on young people's perceptions of access and confidentiality within sexual health settings, with some young people feeling that services might be denied, parental permission required, or confidentiality breached if the person was not legally allowed to be engaging in sexual activity.

Facilitative laws include laws providing for SRE in schools, equality laws and laws imposing a duty of confidentiality on service providers. SRE can facilitate access to services by ensuring that young people are informed and aware of sexual health matters and have the ability to make healthy decisions and protect

themselves. Legal frameworks, particularly in England and Northern Ireland, restrict the ability for young people to receive quality, comprehensive SRE, by failing to make it a core, compulsory subject commencing at a young age (England) or focusing exclusively or heavily on the biological components of SRH (England and Northern Ireland). This has led to significant variation in the extent and quality of SRE among schools in the UK, with some schools providing reasonably comprehensive coverage delivered in an engaging manner, and others delivering no or only very minimal instruction. This in turn has led to wide variation in the level of knowledge of SRH matters among young people according to the school they attend or attended. Where schools are not obliged to provide education on the broader dimensions of SRH, including on healthy relationships and issues of violence and consent, this undermines the ability of young people to have healthy and enjoyable sexual lives and relationships. Further, hetero-normativity of SRE in many schools has caused LGBTI young people to miss out on relevant information and feel stigmatized as a result of their sexuality or gender identity. Lack of quality, comprehensive education on SRH has led to young people finding alternative information sources, including less reliable sources, which can impact negatively on their sexual health.

Laws prescribing confidential access to treatment and advice are extremely important in facilitating access to SRH services, particularly in the presence of more restrictive social, cultural and religious norms that stigmatize sexual activity among young people or outside of marriage / long term relationships. Though not always conceived as a legal duty or right, young people were generally aware that they had an entitlement to receive confidential advice, information and treatment, though there was some uncertainty in relation to the circumstances in which this could be breached. This was seen as being extremely important for facilitating access and removing barriers caused by restrictive social and cultural norms. However, the uncertainty of young peoples of their rights in this area (in particular, as to when confidentiality could be breached, and whether this was determined by a specific age), undermine the facilitative capacity of confidentiality laws. In addition, while it is essential that confidentiality be limited by law in cases where a child protection risk is identified, having a blanket age-determined mandatory reporting obligation, as is the case in Northern Ireland, may have the effect of restricting access to services by young people below this age (13 years). Child protection risks should be considered and responded to on a case-by-case basis, rather than by a pre-determined age.

Equalities law, which protects young people from discrimination on various grounds, can help to facilitate access to SRH services by young people. It can help facilitate access directly by prohibiting a service provider from refusing to give services to young people with particular characteristics, and giving them legal standing to challenge decisions to refuse services on particular grounds. It can also provide an imperative for Government to ensure that services are available to meet the needs of all young people. Lack of legal recognition and protection can have the reverse effect: it may mean that the needs of particular groups of young people will be excluded or marginalised within mainstream service provision. In the UK, the facilitative capacity of equality law is undermined by its exclusion of protection of LGBTI young people in schools (Northern Ireland); and denying explicit legal protection to third gender, genderqueer and intersex young people (England/Wales and Northern Ireland). Lack of legal recognition and protection of third-gender, genderqueer and intersex (young) people can create structural barriers for young people who do not identify in a gender-binary way, as the law provides no imperative for service provision for these persons, and does not provide young people with legal recourse where these services are withheld from them on the basis of their gender identity. In practice, this can have the effect of preventing transgendered, genderqueer and third gender young people from accessing the SRH services that they require.

8.2 Implications for law and policy

8.2.1 Law on sex and relationships education

Comprehensive and compulsory SRE should be a mandatory part of school curricula, and should be introduced before the age of puberty. Legislation should prescribe that SRE should focus not just on reproductive and biological aspects of SRH, but also on relationships, consent and violence, and the emotional and mental aspects of relationships and sexual activity. All schools should also be mandated to include SRE on diverse gender and sexual identities.

Best practices should be collected from schools that provide quality, comprehensive SRE, published and circulated widely among schools in the UK.

8.2.2 Age of sexual consent

The research reveals that age of consent laws may create indirect barriers to young people's access to SRH services. The law in the UK does not prevent young people below the age of consent from accessing services; however, some young people appear to conflate this age with other key laws, like confidentiality and consent to treatment. Awareness-raising of young people around the right to access confidential SRH services regardless of the age of sexual consent should be carried out. Additional research could provide further insight into best practices for legislating the age of sexual consent.

8.2.3 Consent to treatment

Primary legislation should clearly establish a young person's right to access SRH services, independent of parental or other consent;

in order to avoid ambiguity and the risk that informal restrictions will be applied at the discretion of service providers.

8.2.4 Confidentiality

Young people's right to access SRH services confidentially should be established in primary legislation, rather than in guidance only. While the law should provide for reporting by professionals of child protection concerns, the blanket age-based mandatory reporting law in Northern Ireland relating to all children under 13 years who engage in sexual activity should be removed. Child protection risks should be assessed, instead, on a case-by-case basis.

The Department for Education should consider issuing guidance to schools requiring school nurses and other staff to adhere to confidentiality duties contained in Department of Health guidance to health service providers.

8.2.5 Abortion

Abortion in Northern Ireland should be de-criminalized in all circumstances, and unrestricted access to abortion services should be protected under law.

In England/Wales, the law should provide a right for all women and girls to access abortion, to discourage service providers from imposing additional restrictions on access.

8.2.6 Equalities law

Equalities law should be amended to include non-binary gender identities as a protected characteristic and, in Northern Ireland, protection from discrimination on all grounds should be extended to schools.

Endnotes

1. For example, UNFPA, UNAIDS and UNDP in Asia and the Pacific recently joined forces to produce a review of laws and policies affecting young people's access to sexual and reproductive health and HIV services in Asia and the Pacific. Available at: <http://unesdoc.unesco.org/images/0022/002247/224782e.pdf>. Accessed February 2014.
2. Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.
3. Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.
4. Focus group discussion, two girls in a youth group, aged 14 and 15 years, Belfast, 1 October 2013.
5. NGO service provider interview, Centre Manager and Director, Belfast, 3 October 2013.
6. NGO service provider interview, Centre Manager and Director, Belfast, 3 October 2013.
7. Service provider interview, Head Nurse, youth sexual health service, Manchester, 24 June 2013.
8. Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.
9. Focus group discussion, four boys and one girl, aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.
10. Focus group discussion, two boys, 17 years, youth group in Manchester, 24 June 2013.
11. Service provider interview, Service Coordinator, Learning and Development and Sexual Health Services, P3 (Navigator), north-west London, 11 July 2013.
12. Focus group discussion, three girls in homeless women's shelter, Cardiff, 18 July 2013.
13. Focus group discussion, three boys, 17 years, youth group in Manchester, 24 June 2013.
14. Focus group discussion, two girls in a youth group, aged 14 and 15 years, Belfast, 1 October 2013.
15. Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.
16. Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.
17. Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.
18. Focus group discussion, two boys, 17 and 20, youth group, Manchester, 24 June 2013.
19. Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.
20. Focus group discussion, three girls, 13–14 years, youth project, Manchester, 25 June 2013.
21. Focus group discussion with two boys and one girl, aged 14 and 15, attending a youth centre in Croydon (south-east London).
22. Interview, boy, 17 years, youth project, Manchester, 24 June 2013.
23. Focus group discussion, three girls at a homeless women's shelter, Cardiff, 18 July 2013.
24. Interview with young woman, 23 years, youth group, Cardiff, 19 July 2013.
25. Focus group discussion, seven girls in supported housing for young mothers, Cardiff, 18 July 2013.
26. Focus group discussion, three girls, 13–14 years, youth project, Manchester, 25 June 2013.
27. Service provider interview, Service Coordinator of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.
28. Service provider interview, Service Coordinator of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.
29. Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.
30. Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.
31. Focus group discussion, two boys, aged 18–24, transgender youth group, London, 26 September 2013.
32. Provided to researcher in service provider interview with specialist transgender service health provider, central London, 28 August 2013.
33. Service provider interview, Service Coordinator, Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.
34. Service provider interview, Head of Education, youth sexual health service, Manchester, 24 June 2013.

35 NGO service provider (1) interview, Centre Manager and Director, Belfast, 3 October 2013.

36 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

37 Service provider interview, Service Coordinator, Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

38 Focus group discussion, two boys, transgender youth group, London, 26 September 2013.

39 Focus group discussion, two boys, transgender youth group, London, 26 September 2013.

40 NGO service provider interview, Centre Manager and Director, Belfast, 3 October 2013.

41 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

42 Service provider interview, Head Nurse, youth sexual health service, Manchester, 24 June 2013.

43 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

44 In England, policy goals were recently set out in the Department of Health document, *A Framework for Sexual Health Improvement in England* (March 2013): "The Government wants to improve sexual health and our ambition is to improve the sexual health and wellbeing of the entire population. To do this, we must: Reduce inequalities and improve sexual health outcomes; build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex; and recognize that sexual ill-health can affect all parts of society. In Wales, according to the Government's *Sexual Health and Wellbeing Action Plan*, 2010–2015, policy aims are to: improve sexual health and wellbeing of the population; narrow sexual health inequalities; and develop a society that supports open discussion about relationships, sex and sexuality. In Northern Ireland, the *Sexual Health Promotion Strategy and Action Plan 2008–2013*, has as one of its objectives, enabling "all people to develop and maintain the knowledge, skills and values necessary for improving sexual health and wellbeing".

45 Focus group discussion, college class, five boys, aged 20–22 years, Lisburn, 1 October 2013.

46 Service provider interview, Head Nurse, youth sexual health service, Manchester, 24 June 2013.

47 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

48 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

49 Interview with specialist transgender service health provider, central London, 28 August 2013.

50 IPPF, *Why is it important to develop capacities for autonomous decision-making?* p.10.

51 IPPF, *Why is it important to develop capacities for autonomous decision-making?* p.10.

52 UK Government, Department for Education and Employment, *Sex and Relationship Education Guidance*, July 2000, para. 1.18. Available at: <http://media.education.gov.uk/assets/files/pdf/s/sex%20and%20relationship%20education%20guidance.pdf>. Accessed: April 2014.

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54 IPPF, *Why is it important to develop capacities for autonomous decision-making?* p.9.

55 Under the *Learning and Skills Act 2000*.

56 UK Government, Department for Education and Employment, *Sex and Relationship Education Guidance*, July 2000, para. 1.30. Available at: <http://media.education.gov.uk/assets/files/pdf/s/sex%20and%20relationship%20education%20guidance.pdf>. Accessed: April 2014.

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58 Northern Ireland Human Rights Commission, *Education Reform in Northern Ireland: A Human Rights Review*, p.24. Available at: <http://www.nihrc.org/documents/human%20rights%20education/Education%20Reform%20in%20Northern%20Ireland-%20A%20Human%20Rights%20Review.pdf>. Accessed: April 2014.

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60 Department of Education Northern Ireland, National Curriculum website. Available at: <http://www.nicurriculum.org.uk/microsite/financial_capability/key_stage3/big_picture/>. Accessed: April 2014.

61 FPA (2012) *Relationships and Sexuality Education: Factsheet. Northern Ireland*. Available at: <http://www.fpa.org.uk/sites/default/files/northern-ireland-relationships-and-sexuality-education-in-schools.pdf>. Accessed: April 2014.

62 Department of Education Northern Ireland, *Relationships and Sexuality Education: Guidance for Post-primary Schools*, N.D, p.24. Available at: <http://www.deni.gov.uk/2001-15-3.pdf>. Accessed: April 2014.

63 The Rainbow Project, Education in Northern Ireland, Website, last accessed 20/12/13. Available at: <http://www.rainbow-project.org/services/education-services/education-in-ni>. Accessed: April 2014.

64 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

65 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

66 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

67 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

68 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

69 Focus group discussion, two boys, 17 and 20, youth group, Manchester, 24 June 2013.

70 Focus group discussion, 10 girls, aged 17–20 years, college class (2), Lisburn, 1 October 2013..

71 Service provider interview, Head of Education, youth sexual health service, Manchester, 24 June 2013.

72 Service provider interview, Head of Education, Brook (sexual health service provider, Manchester, 24 June 2013.

73 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

74 NGO service provider (2) interview, Director, Belfast, 3 October 2013.

75 Focus group discussion, two 21 year-old young men, Supported Housing Unit, London, 3 August 2013.

76 Service provider interview, Head of Education, youth sexual health service, Manchester, 24 June 2013.

77 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

78 Service provider interview, Head of Education, youth sexual health service, Manchester, 24 June 2013.

79 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

80 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

81 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

82 Interview with 20 year old young man, at a supported housing project in London, 2 August 2013.

83 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

84 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

85 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

86 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

87 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

88 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

89 Service provider interview, Head Nurse, youth sexual health service, Manchester, 24 June 2013.

90 Service provider interview, Education Head, youth sexual health service, Manchester, 24 June 2013.

91 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

92 Focus group discussion, seven girls in supported housing for young mothers, Cardiff, 18 July 2013.

93 Interview with young woman, 23 years, youth group, Cardiff, 19 July 2013.

94 Sexual health advisor, homeless shelter for young mothers, Cardiff, 18 July 2013.

95 NGO service provider (1) interview, Centre Manager and Director, Belfast, 3 October 2013.

96 Focus group discussion, 10 girls, aged 17–20 years, college class (2), Lisburn, 1 October 2013.

97 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

98 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

99 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

100 Service provider interview, Education Head, youth sexual health service, Manchester, 24 June 2013.

101 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

102 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

103 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

104 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

105 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

106 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

107 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

108 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

109 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

110 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

111 Ibid.

112 Ibid.

113 Ibid.

114 Focus group discussion, college class (3), one boy and four girls, aged 18–21 years, Lisburn, 1 October 2013.

115 NGO service provider (1) interview, Centre Manager and Director, Belfast, 3 October 2013.

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117 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

118 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

119 Focus group discussion, two boys, transgender youth group, London, 26 September 2013.

120 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

121 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

122 Focus group discussion, 12 girls, aged 16–17 years, college in Buckinghamshire, 24 September 2013.

123 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

124 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

125 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

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128 Department of Education Northern Ireland, *Relationships and Sexuality Education: Guidance for Post-primary Schools*, N.D, p.24. Available at: <http://www.deni.gov.uk/2001-15-3.pdf>. Accessed: April 2014.

129 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

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132 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

133 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

134 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

135 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

136 Lesbian, gay, bisexual, transgender, queer, intersex, asexual.

137 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

138 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

139 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

140 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

141 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

142 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

143 NGO service provider (2) interview, Director, Belfast, 3 October 2013.

144 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

145 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

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151 NGO service provider (1) interview, Centre Manager and Director, Belfast, 3 October 2013.

152 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

153 Focus group discussion, two boys and one girl, aged 14 and 15, attending a youth centre in Croydon (south-east London).

154 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

155 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

156 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

157 Ibid.

158 Focus group discussion, seven girls in supported housing for young mothers, Cardiff, 18 July 2013.

159 Service provider interview, Head of Education, youth sexual health service, Manchester, 24 June 2013.

160 Focus group discussion, 12 girls aged 16–17 years, college in Buckinghamshire, 24 September 2013.

161 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

162 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

163 Focus group discussion, three boys and five girls, aged 15–19 years, youth group for excluded young people, Belfast, 2 October 2013.

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166 G*illick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

167 G*illick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402.

168 G*illick v West Norfolk and Wisbech Area Health Authority*[1985] 3 All ER 402.

169 Service provider interview, Head Nurse, youth sexual health service, Manchester, 24 June 2013.

170 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

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178 Interview with young woman, 17 years, sexual health service, London, 19 June 2013.

179 Interview, Boy, 17 years, youth project, Manchester, 24 June 2013.

180 Service provider interview, counsellor, Brook (sexual health service provider), Manchester, 25 June 2013.

181 Focus group discussion, two boys, 17 years, youth group in Manchester, 24 June 2013.

182 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

183 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

184 Interview with young woman, 17 years, sexual health service, London, 19 June 2013.

185 Focus group discussion with two boys and one girl, aged 14 and 15, attending a youth centre in Croydon (south-east London).

186 Focus group discussion, two boys, 17 and 20, youth group, Manchester, 24 June 2013.

187 Focus group discussion, two boys, 17 years, youth group in Manchester, 24 June 2013.

188 Interview with specialist transgender service health provider, central London, 28 August 2013.

189 NGO service provider (1) interview, Centre Manager and Director, Belfast, 3 October 2013.

190 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

191 NGO service provider (1) interview, Centre Manager and Director, Belfast, 3 October 2013.

192 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

193 Focus group discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

194 Service provider interview, Head of Education, youth sexual health service, Manchester, 24 June 2013.

195 Focus group discussion with two boys and one girl, aged 14 and 15, attending a youth centre in Croydon Focus Group Discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013 (south-east London).

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199 Focus group discussion, two girls, both 19 years, college in London, 21 June 2013.

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201 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

202 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

203 Focus group discussion, 10 girls, aged 17–20 years, college class (2), Lisburn, 1 October 2013.

204 Focus group discussion, two girls in a youth group, aged 14 and 15 years, Belfast, 1 October 2013.

205 Focus group discussion, two boys and one girl, aged 14 and 15, attending a youth centre in Croydon (south-east London).

206 Focus group discussion, three girls in homeless women's shelter, Cardiff, 18 July 2013.

207 Focus group discussion, two 21 year-old young men, Supported Housing Unit, London, 3 August 2013.

208 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

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210 Focus group discussion with two boys and one girl, aged 14 and 15, attending a youth centre in Croydon (south-east London).

211 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

212 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

213 Focus group discussion, seven girls in supported housing for young mothers, Cardiff, 18 July 2013.

214 Focus group discussion, two girls in a youth group, aged 14 and 15 years, Belfast, 1 October 2013.

215 Focus group discussion, 10 girls, aged 17–20 years, college class (2), Lisburn, 1 October 2013.

216 Service provider interview (specialist provider of support to women from the Republic of Ireland and Northern Ireland travelling to England to access an abortion), London, 23 August 2013.

217 Section 1, Abortion Act 1967 (this section also lists other circumstances that apply in rarer circumstances in which a woman can terminate a pregnancy).

218 Section 1(a), Abortion Act 1967.

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221 Service provider interview, counsellor, youth sexual health service, Manchester, 25 June 2013.

222 Service provider interview, Head Nurse, youth sexual health service, Manchester, 24 June 2013.

223 Service provider interview, Service Coordinator, of Learning and Development and Sexual Health Services, youth centre, north-west London, 11 July 2013.

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225 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

226 Focus group discussion, one girl and one boy, 16 and 17 years, college class (4), Lisburn,.

227 Focus group discussion, four boys and one girl aged 19–24 years, youth group, Derry/Londonderry, 2 October 2013.

228 Service provider interview (specialist provider of support to women from the Republic of Ireland and Northern Ireland travelling to England to access an abortion), London, 23 August 2013.

229 Service provider interview (specialist provider of support to women from the Republic of Ireland and Northern Ireland travelling to England to access an abortion), London, 23 August 2013.

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241 Section 19, *Equality Act 2010*.

242 Section 4, *Equality Act 2010*.

243 Section 7, *Equality Act 2010*.

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245 Interview with specialist transgender service health provider, central London, 28 August 2013.

246 Interview with specialist transgender service health provider, central London, 28 August 2013.

247 Interview with specialist transgender service health provider, central London, 28 August 2013.

248 Focus group discussion, two boys, aged 18–24, transgender youth group, London, 26 September 2013.

249 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

250 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

251 Focus Group Discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

252 Focus group discussion, nine young people, aged 17–25 years, youth sexual health service, central London, 20 June 2013.

253 Focus Group Discussion, six girls and two boys, aged 16–24 years, youth group, Belfast, 30 September 2013.

254 Focus group discussion with two boys and one girl, aged 14 and 15, attending a youth centre in Croydon (south-east London).

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256 Interview, Boy, 17 years, youth project, Manchester, 24 June 2013.

257 Focus group discussion, online national session with three boys and seven girls, aged 16–24 years, from: north-west England, south-east England, East Midlands, Northern Ireland, south London, east England, south-west England, Cumbria and West Midlands, 24 September 2013.

258 Focus group, 13 young people, aged 14–17 years, LGBT youth group, London, 19 June 2013.

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267 Focus group discussion, college class, five boys, aged 20–22 years, Lisburn, 1 October 2013.

268 Focus group discussion, two girls in a youth group, aged 14 and 15 years, Belfast, 1 October 2013.

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Over-protected and under-served

A multi-country study on legal barriers to young people's access to sexual and reproductive health services

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

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Across the world, laws create barriers to young people accessing the sexual and reproductive health services that they need. Often, the rationale for such laws is cited as 'protection' but, in reality, they have the opposite effect.

While there is an extensive body of literature that explores social, cultural and economic barriers to young people's access to SRH services in a range of contexts around the world, much less is known about the role of law in influencing and shaping their access. This is despite the fact that every state around the world, without exception, has developed legislation that is in some manner designed to purposefully regulate and restrict access to SRH services.

This exploratory research project contributes to the evidence base on the barriers that prevent young people from accessing SRH services, and the hope is that it will inform advocacy and programmatic work aimed at fulfilling young people's sexual rights. The research took place in three countries: El Salvador, Senegal and the UK (England, Wales and Northern Ireland). Young people themselves were the main respondents, with their views, opinions and perceptions on the role of the law remaining central to the findings and recommendations.

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