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HAS THE U.K. VIOLATED ITS INTERNATIONAL OBLIGATIONS BY FAILING TO INTRODUCE MANDATORY SEX EDUCATION IN SCHOOLS?

*Morgane Landel**

INTRODUCTION

It is not often that a nation finds itself in violation of its international treaty obligations regarding fundamental human rights as a result of systemic neglect or inaction at a national policy level. However, the United Kingdom's ("U.K.'s") failure to mandate sex education in its public schools may amount to such a violation. According to the World Health Organization ("WHO"), the United Kingdom has one of the highest rates of teenage pregnancy in the developed world.¹ In 1999, having recognized the need to address this problem, the U.K. government ordered a report from the Social Exclusion Unit, a government department established in 1997² to make recommendations and develop strategies to reduce teenage pregnancy.³ After reviewing the report, the U.K. government decided to allocate sixty million pounds to carry out the Unit's recommendations.⁴ In 2000, the government created an Independent Advisory Group on Teenage Pregnancy⁵ and identified three main goals to be achieved by 2010: (1) a fifty percent reduction in the number of citizens

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1. From 2000 to 2006, teenage pregnancy was estimated at a rate of 27 per 1,000 girls. This is more than twice the rate in Germany, 11 per 1,000 girls, and three times the rate in France, 8 per 1,000 girls. WORLD HEALTH ORGANIZATION [WHO], WORLD HEALTH STATISTICS 2008, at 98–103 (2008), available at http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf.

2. See Cabinet Office: Social Exclusion Task Force, About Us, http://www.cabinetoffice.gov.uk/social_exclusion_task_force/about_us.aspx.

3. See SOCIAL EXCLUSION UNIT, TEENAGE PREGNANCY, 1999, Cm. 4342, at 2, available at http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/teenage_preg.pdf.

4. See Caroline Mawer, *Preventing Teenage Pregnancies, Supporting Teenage Mothers*, 318 BRIT. MED. J. 1713, 1713 (1999).

5. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 9; see also The Teenage Pregnancy Independent Advisory Group (Dec. 15, 2009), <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/tpiag/tpiag/>.

under eighteen who become pregnant;⁶ (2) a “firm downward trend” in the number of citizens under sixteen who conceive; and (3) a sixty percent increase in the proportion of teenage parents who are able to mitigate the risk of social exclusion by continuing on with education, training, or employment.⁷ This new advisory group was to facilitate and monitor the government’s efforts toward achieving these goals by providing an annual progress report on teenage pregnancy.⁸

The government defines “conception” as pregnancy that results in either one or more live births or a legal abortion.⁹ The latest government statistics show that from 1998 to 2006 the rate of conception among teenage girls age thirteen to eighteen fell, but only slightly.¹⁰ Even if the next annual statistics report—not yet published as of this writing—shows that teenage pregnancy continued to decline at the same rate until 2010, the government will still have failed to meet its targeted fifty percent reduction in conception by those under eighteen.¹¹

The Social Exclusion Unit’s original report identified three main causes of the high rate of teenage pregnancy: “low expectations,” “ignorance,” and “mixed messages.”¹² First, children who live in impoverished or otherwise disadvantaged communities tend to have low expectations for themselves, specifically in relation to education and employment.¹³ Teens that have had emotionally and financially secure upbringings are more likely to pin their hopes for the future on education and are, therefore, likely to consider teenage pregnancy an obstacle to their life goals.

6. This figure is calculated from the statistics compiled in 1998 as a starting point

7. See generally Every Child Matters, About the Teenage Pregnancy Strategy, <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/about/stategy> (last visited Nov. 23, 2008).

8. Every Child Matters, The Teenage Pregnancy Independent Advisory Group, <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/tpiag/tpiag/>.

9. OFFICE OF NATIONAL STATISTICS, CONCEPTION STATISTICS 1 (2005), available at <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/statistics/statistics/> (follow “Conception Statistics – Definitions and Sources” link).

10. *Id.* For example, for those under eighteen, the rate for ages 15–17 has fallen in England from 46.6 per 1,000 girls to 40.4 per 1,000 girls, and from 8.8 per 1,000 girls to 7.7 per 1,000 girls for girls ages 13–15. *Cf. id.*

11. This Article will primarily focus on the situation in England because Scotland and Northern Ireland have complete autonomy in education and health policy, while Wales has some autonomy in those areas. This Article, however, will refer to the U.K. when referring to the government because England does not have a separate government and the U.K. parliament legislates on health and education in England. In addition, when the article refers to teenage pregnancy, it refers to teenagers under the age of 18.

12. SOCIAL EXCLUSION UNIT, *supra* note 3, at 7.

13. *Id.*

Meanwhile, those who do not view education as a necessity are more likely to consider teenage parenthood a legitimate and acceptable path.¹⁴ Of course, environment can increase the likelihood of teenage pregnancy in a number of ways. While it is perhaps unsurprising that conception rates in England's most impoverished areas have been up to six times higher than in affluent areas,¹⁵ children who have experienced social exclusion or foster care also conceive at an above average rate, as do children whose parents conceived when one or both were teens.¹⁶

The second cause identified in the Social Exclusion Unit's report was "ignorance." Children and teens ignorant of facts about pregnancy, sexually transmitted diseases, and intimate relationships are more likely to engage in unprotected sex.¹⁷ Finally, the third cause identified in the report, "mixed messages," refers to the range of conflicting viewpoints children and teens are exposed to in regard to the appropriateness of sexual activity. While media bombard teens with explicitly sexual images and messages, accurate information about sex is swept under the rug.¹⁸ Needless to say, mixed messages are a part of a broader problem of limited availability of quality information for teens regarding sexual health.

The above trends also reflect a cultural disconnect. In the U.K., a vocal minority oppose abortion, sex education, and sexual health services for girls under sixteen.¹⁹ As a result, the government is hesitant to tackle these issues head on.²⁰ Meanwhile, some school officials have made clear that they would like to avoid garnering for their respective schools any kind of reputation for providing "good" sex education—apparently, they fear unwelcome negative attention.²¹ Opponents of contraception and other sexual health services use the media to attack schools and health workers persistently.²²

14. *Id.* at 31.

15. OSMO KONTULA, REPRODUCTIVE HEALTH BEHAVIOUR OF YOUNG EUROPEANS: THE ROLE OF EDUCATION AND INFORMATION 62 (2004).

16. *Id.* at 17.

17. *Id.* at 7. This article focuses on this cause as the key solving the apparent violations of human rights from the standpoint of England's international treaty obligations. For England's international legal obligations, see discussion *infra* Part II.

18. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 7.

19. KONTULA, *supra* note 15, at 66.

20. *Id.*

21. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 40.

22. TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, ANNUAL REPORT 2007/08 (2008), available at <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/tpiag/tpiag/>.

The issue of abortion is still hotly debated among various groups and U.K. politicians.²³ In 2007, it was estimated that twenty-four percent of general medical practitioners in England would never refer a woman for an abortion on the grounds of conscientious objections.²⁴ Studies further show that three in four teenage pregnancies in the U.K. are not planned, and only one in four teenagers use contraception.²⁵ The difference between the number of sexually active teenagers and those that plan pregnancy implies a gap between the preferences of most sexually active teenagers and their ability to comprehend the consequences of having sex without using contraception. This implies a gap in information—in other words, a gap in education.

Pursuant to several international treaties, the U.K. has an obligation to take steps to empower women to make informed decisions about their own health.²⁶ This is not to suggest that teenagers should not have children. However, the impact of teenage pregnancy often leads to lack of education and continued dependence on benefits, which our society considers to be undesirable.²⁷ The presumption here is that teenage pregnancy does not occur as a result of informed choice but as a result of ignorance. The premise is not that teenage pregnancy should be eliminated but that it should be the result of informed choice. The U.K. must remedy this problem by ensuring access to adequate information through sex education. Teenage girls will then be able to make informed choices about pregnancy. Only then will the U.K. be on the path to compliance with its international obligations as set forth below.

Currently, England lacks a standard curriculum for sex education, and sex education is not mandatory in primary and secondary schools. In order to comply with its international treaty obligations, the U.K. must create a comprehensive and mandatory sex education program that

23. As recently as May 2008, the U.K. Parliament voted on several bills to lower the time period for access to abortion from 24 weeks, to 22, 20, 16, and 12 weeks. *See MP's Reject Cut in Abortion Limit*, BBC NEWS, May 21, 2008, http://news.bbc.co.uk/2/hi/uk_news/politics/7412118.stm. All were voted against, but the issue remains a contested one. *Id.*

24. *See* Education for Choice: More on UK Abortion Law, <http://www.efc.org.uk/Foryoungpeople/Factsaboutabortion/MoreonUKabortionlaw>.

25. KONTULA, *supra* note 15, at 61.

26. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, ¶ 39, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

27. Comm. on the Elimination of Discrimination Against Women, *Report of the Committee on the Elimination of Discrimination Against Women*, pt. 2, ¶ 309, U.N. Doc. A/54/38/Rev.1 (June 25, 1999) [hereinafter Report of the Committee on the Elimination of Discrimination Against Women].

enables all school children to make informed choices about their sexuality. This program must provide the biological facts of reproduction and provide practical information about sex, allowing children to make an informed choice about their sexuality. While practical remedies in the international sphere are beyond the scope of this Article, the success of such a program could be measured against subsequent changes in the rate of unplanned teenage pregnancies.

Part I of this Article looks at the problem of ignorance as a significant cause of the high teenage pregnancy rate in the U.K. and argues that sex education in schools is the proper primary remedy. Part II of this Article argues that the societal consequences of insufficient sex education—health risks and other social costs—violate the U.K.’s obligations under various international treaties. In sum, the U.K.’s failure to provide sufficient sex education harms its people, and the government must remedy this harm by establishing a standard sex education program. Only when all children and teens in the U.K. are capable of making informed choices about pregnancy will the U.K. then be on the path to compliance with its international obligations.

I. WHY TEENAGE PREGNANCY MATTERS

Teenage pregnancy is admittedly controversial. Of course, it must be correct that some teenagers are capable, both physically and mentally, of becoming parents and looking after their children. Still, the common Western view is that teenage parenthood is undesirable.²⁸ The U.N. Economic and Social Council has articulated this view and has acknowledged that teenage pregnancy is a growing issue throughout the world due to “growing awareness that early . . . [pregnancy] poses a health risk for the mother and the child and may truncate . . . [the mother’s] educational career, and threaten her economic prospects, her earning capacity[,] and her overall well-being.”²⁹ But the controversy goes beyond the economic prospects of teenage parents.

Teenage pregnancy leads to social exclusion and other disadvantages, and, ultimately, it is correlated with an increase in the likelihood that the teenager’s child will become a teenage parent him or herself in the long run.³⁰ The Committee on the Elimination of Discrimination Against Women highlighted these problems in 1999 in its Concluding Observa-

28. See *supra* notes 29–30 and accompanying text.

29. U.N. Econ. & Soc. Council [ECOSOC], Comm’n on Population and Dev., *Concise Report on World Population Monitoring: Reproductive Rights and Reproductive Health*, ¶ 25, U.N. Doc. E/CN.9/1996/2 (Jan. 15, 1996).

30. John Tripp & Russell Viner, *ABC of Adolescence: Sexual Health, Contraception, and Teenage Pregnancy*, 330 *BMJ: BRIT. MED. J.* 590, 591 (2005).

tions to the U.K.,³¹ noting that early childbearing results in “lower educational achievement, higher levels of poverty[,] and greater reliance on social welfare.”³² While there is a program in place called “Care2Learn” that provides teenage parents with welfare benefits so that they can return to school, these benefits cannot fully cover the costs of childcare, especially in London.³³ “Care2Learn” is also only available to around 7,000 young parents, whereas the government’s own target has been to make it available to 10,000 young parents.³⁴ If teenage mothers are unable to re-enter education or training after their pregnancy, they are unlikely to have access to well-paying jobs or be admitted to higher education and are thus more likely to continue to rely on the welfare system.

A. Is Teenage Pregnancy a Human Rights Violation?

It is difficult to consider teenage pregnancy a human rights violation since it involves the birth of a human being. The term, “human rights violation,” as a label, carries a strong negative connotation that frustrates the inherent dignity of the newborn.³⁵ However, this Article does not attribute such a label to the fact of birth itself. Instead, the violation occurs before the child is born; it is a violation on the part of the state, for failing to implement concrete measures to reduce the rate of teenage pregnancy. Most importantly, the state should provide adequate information to children and teens.

Teenage parents have the right to make informed choices about sexual health, and the government may have violated teens’ rights by rendering them unable to deal intelligently with pregnancy. This article, however, does not argue that if this were remedied, it would lead to a dramatic decrease in the number of teenage pregnancies. Instead, teenage pregnancy would be the result of an informed choice, by a teenage girl, possessing a full spectrum of appropriate information. Given the current statistics, it seems likely that the provision of information would however decrease the rate of teenage pregnancy. Arguably, the current institutional impediments to information flow are effectively violating the human rights of teenage girls if we presume the State may not obstruct and must actively

31. Report of the Committee on the Elimination of Discrimination Against Women, *supra* note 27.

32. *Id.*

33. TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, *supra* note 22, at 31.

34. *Id.*

35. See *Tysiac v Poland*, Eur. Ct. H.R. (2007), at ¶ 15 (Judge Borrego Borrego, dissenting), available at http://www.echr.coe.int/echr/Homepage_EN (“[T]here is a polish child . . . whose right to be born contradicts the Convention.”).

promote informed decision-making among teenage girls with respect to sex and pregnancy.

B. Teenage Pregnancy in England: Is Abortion a Readily Available Solution?

A number of initiatives were launched as a result of the reports described above. For example, a month-long media campaign sought to encourage teenagers to take control of their lives and their choices, and to take responsibility for those choices.³⁶ A national helpline called Sexwise now provides advice to teenagers on matters of sexual health.³⁷ Teens have access to free contraception. Doctors or local sexual health clinics may now provide condoms to teenagers.³⁸ The contraceptive methods, however, vary with local health services throughout England.³⁹ As a result, in February 2008, the U.K. government announced new funding worth 26.8 million pounds to improve access to contraception.⁴⁰ The Independent Advisory Group on Teenage Pregnancy has welcomed this new funding approach⁴¹ but has stressed nonetheless that some Primary Care Trusts, which are responsible for the allocation of resources within a particular area, have not yet set up a special service to deal with teenage pregnancy.⁴²

It is noteworthy that abortion is legal in England under the Abortion Act of 1967.⁴³ An abortion, however, must be authorized by two medical practitioners, except in an emergency.⁴⁴ For example, a doctor who makes the initial referral to the hospital and the doctor who performs the

36. INDEPENDENT ADVISORY GROUP ON TEENAGE PREGNANCY, FIRST ANNUAL REPORT 5 (2001), available at <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/tpiag/tpiag/>.

37. *Id.* It is noteworthy, however, that some of the information being disseminated to children through the government's own website www.ruthinking.org is inaccurate. See RUTHinking.co.uk, Sex & the Law, <http://www.ruthinking.co.uk/the-facts/search/articles/sex-and-the-law.aspx> (last visited Feb. 24, 2010) (states that it is illegal for anyone under 16 to have sex or to have an abortion after 24 weeks). This reflects the government's inexperience and lack of commitment to providing quality sexual health information to teenagers.

38. National Health Services, Getting Contraception, <http://www.nhs.uk/Livewell/Sexandyoungpeople/Pages/Gettingcontraception.aspx>.

39. See TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, ANNUAL REPORT 2008/09, at 11 (2009), available at <http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/tpiag/tpiag/>.

40. *Id.* at 12.

41. *Id.*

42. See TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, *supra* note 22, at 9–10.

43. See generally Abortion Act, 1967, c.87 (Eng.).

44. See National Health Service, Abortion - Introduction, <http://www.nhs.uk/Conditions/Abortion/Pages/Introduction.aspx?url=Pages/what-is-it.aspx> (last visited March 1, 2010).

abortion may authorize the procedure.⁴⁵ In the first 24 weeks of pregnancy, the doctors must form an “opinion” in “good faith” that forgoing the abortion would cause injury to the fetus or to the mother’s mental or physical health.⁴⁶ There are no time restrictions, however, if the doctors certify that the abortion is necessary to prevent a grave permanent injury or a life-threatening risk to the mother or the child.⁴⁷ In practice, abortions are covered by the National Health Service, which means they are free.⁴⁸ To be referred to a hospital for an abortion, a woman must first visit her local doctor or sexual health clinic.⁴⁹ This, however, can take up to four to five weeks.⁵⁰ The delay is problematic because teenagers may delay obtaining information in the first instance, which will further postpone the procedure. Furthermore, it is well-documented that having a late-term abortion may endanger the mother’s health.⁵¹ The 2006 statistics show that a majority of women had abortions in the first nine weeks of pregnancy.⁵²

Beyond the Abortion Act of 1967, there are no specific abortion-related legal provisions pertaining to those under eighteen. Generally, teenagers can obtain abortions without parental consent.⁵³ In 2004, government guidelines stated that doctors should provide confidential advice on sexual health to anyone under sixteen, provided the person “understands the advice provided and its implications” and her “physical or mental health would otherwise be likely to suffer and so [the] provision of advice or treatment is in their best interest.”⁵⁴ The doctor should breach the duty of confidentiality only in exceptional circumstance

45. *Id.*

46. Abortion Act, 1967, c.87, § 1 (Eng.).

47. *Id.*

48. See National Health Service, *supra* note 44.

49. See DEPARTMENT OF HEALTH, BETTER PREVENTION, BETTER SERVICES, BETTER SEXUAL HEALTH—THE NATIONAL STRATEGY FOR SEXUAL HEALTH AND HIV 28 (2001), available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003133.

50. See *id.*

51. See *id.*

52. See *MP’s Reject Cut in Abortion Limit*, *supra* note 23 (over 50 percent of women in England and Wales had abortions in the first 9 weeks, just under 35 percent had abortions between 9 and 12 weeks, under 10 percent had abortions between 13 and 19 weeks, and under 3 percent had abortions after the 20th week).

53. Cf. Abortion Act, 1967, c.87 (Eng.).

54. DEPARTMENT OF HEALTH, BEST PRACTICE GUIDANCE FOR DOCTORS AND OTHER HEALTH PROFESSIONALS ON THE PROVISION OF ADVICE AND TREATMENT TO YOUNG PEOPLE UNDER 16 ON CONTRACEPTION, SEXUAL AND REPRODUCTIVE HEALTH 3 (2004), available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086960.

where the health, safety, and welfare of the child are at serious risk.⁵⁵ In addition, the government recommends that doctors should try to persuade teenagers to speak to their parents or other adults about sexual health choices.⁵⁶ Nevertheless, the doctors should provide sexual health services in the teenager's best interest even if the teens do not want to speak to their parents.⁵⁷ In 2006, the High Court held that parents do not have the right to be informed of their children's sexual health.⁵⁸ The Court found that the 2004 guidelines do not violate a parent's right to respect for private and family life.⁵⁹ In sum, teens are able to obtain contraceptives or get abortions free of charge and in confidence—if they are aware of these options and know where to go.

C. Why Sex Education is Necessary?

The benefits of sex education in schools are well documented.⁶⁰ The government has recognized that “effective sex and relationship education is essential if young people are to make responsible and well-informed decisions about their lives.”⁶¹ Comprehensive sex education in schools is likely to help teenagers delay sexual activity while promoting the use of contraception.⁶² The argument that sex education encourages teenage sex has been discredited.⁶³ Meanwhile, programs that promote abstinence have not been shown to reduce the rate of teenage pregnancy.⁶⁴

Without sexual health education, teenagers make decisions without accurate information. For example, 75% of those under sixteen, and almost 50% of sixteen to nineteen-year-olds fear that if they visit a sexual health clinic, the doctor will inform their parents of the reasons for the visit.⁶⁵ Thus, they avoid the clinic. Another study found that less than half of the relevant age group sampled is aware that emergency contraception is

55. *Id.* at 3.

56. *Id.*

57. *Gillick v West Norfolk and Wisbech Area Health Auth.*, [1986] A.C. 112, 174 (H.L.) (appeal taken from Eng. (known as the Fraser Guidelines)).

58. *The Queen v. Sec'y of State for Health (The Family Planning Association)*, [2006] Q.B. 539, 559–68 (appeal taken from Eng.).

59. *Id.* This right is set forth in Article 8 of the European Convention on Human Rights

60. See generally DEPARTMENT FOR EDUCATION AND EMPLOYMENT, SEX AND RELATIONSHIP EDUCATION GUIDANCE 3 (2000), available at <http://www.dcsf.gov.uk/sreguidance/sexeducation.pdf>; SOCIAL EXCLUSION UNIT, *supra* note 3, at 39.

61. DEPARTMENT FOR EDUCATION AND EMPLOYMENT, *supra* note 60, at 3.

62. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 36.

63. KONTULA, *supra* note 15, at 75.

64. Tripp & Viner, *supra* note 30, at 590.

65. KONTULA, *supra* note 15, at 63.

available within the first 72 hours after intercourse.⁶⁶ In fact, most teens do not even know that this measure is available over the counter to those over sixteen and, in some instances, to those under sixteen as well.⁶⁷ If sex education explained the confidentiality requirement, teens would not make false assumptions about the implications of visiting their doctors; thus, they may be more willing to seek medical advice. In sum, sex education is necessary because a lack of knowledge about sexual health can prevent teens from seeking out doctors and, more generally, from making informed choices about sexual behavior and contraception.

D. The Current State of Sex Education in Schools

In England, education is mandatory only until age sixteen,⁶⁸ so the following discussion is limited to that age group. The two issues of concern are that sex education is not mandatory and lacks a standard curriculum.⁶⁹ Sexual and Relationship Education (“SRE”) is taught as part of the Personal and Social Health Program (“PHSE”). PHSE is designed to provide pupils with information to make the right choices in relation to finances, health, drugs, alcohol, sex, and relationships.⁷⁰ Under the Learning and Skills Act of 2000, which amended the Education Act of 1996, the principal and the school governing body are responsible for setting out the content of sex education.⁷¹ In doing so, the schools have a duty to consider governmental guidelines, if any are issued.⁷² The governmental guidelines must ensure that sex education is appropriate for the students in light of age and cultural and religious background.⁷³ As a result, sex education policies vary from school to school.⁷⁴ For example, a survey has shown that 55% of students age twelve to fifteen

66. Tripp & Viner, *supra* note 30, at 592.

67. *Id.* at 590.

68. See Department for Children, Schools and Families, Attendance FAQs, <http://www.dcsf.gov.uk/school-attendance/faq/> (last visited Nov. 29, 2008).

69. A 2007 survey carried out by the U.K. Youth Parliament found that 40 percent of children and teens ages 11 to 18 receiving sex education thought that it was poor or very poor and 33 percent thought it was average. U.K. YOUTH PARLIAMENT, SRE ARE YOU GETTING IT? 4 (2007), available at <http://www.ukyouthparliament.org.uk/campaigns/sre/AreYouGettingIt.pdf>.

70. Press Release, Dep't for Children, Sch. and Families, Ed Balls Confirms All Young People to Learn Personal Social Health and Economic Education, available at http://www.dcsf.gov.uk/pns/DisplayPN.cgi?pn_id=2009_0208.

71. Education Act, 1996, c. 56, § 404, amended by Learning and Skills Act, 2000, c. 21, § 148 (Eng.).

72. *Id.* at § 351.

73. *Id.* at § 403.

74. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 39.

were not taught how to use a condom as part of sex education.⁷⁵ This shows a discrepancy in what is being taught in schools. Other schools expressly decline to teach sex education.⁷⁶ It is estimated that 10% of primary schools (for children age five to eleven) do not have a sex education policy, and this means girls may get their first period without having any knowledge of what it is.⁷⁷

Voluntary participation in sex education is also a problem. A parent may opt out of sex education for her child as long as no part of it falls within the national curriculum.⁷⁸ About 1% of parents withdraw children from sex education.⁷⁹ In practice, the only aspect of sex education included in the national curriculum, and thus mandatory in all schools, is the biological aspect of reproduction. It is taught to students age fourteen to sixteen, and includes lessons about hormonal contraception such as the pill or injections.⁸⁰ It does not, however, include any discussion of non-hormonal contraception, such as condoms, or post-conception options, such as abortion.⁸¹

Because SRE is not part of the national curriculum, it is not prioritized. As a result, training of teachers in SRE is voluntary; thus, training attracts teachers who are already responsive to the needs of the program. Also, SRE does not have a standard curriculum.⁸² At the same time, access to health services in schools is patchy and depends on individual teachers and nurses.⁸³ The SRE program is underfunded and not automatically evaluated during inspections by the Office for Standards in Education, Children's Services and Skills ("OFSTED"), which means that SRE is not monitored for content and effectiveness at the national level.⁸⁴

With a view toward remedying the deficiencies in sex education, the government issued guidelines in 2000 as to the proper approach to the topics that are central to SRE—particularly, avoidance of unwanted pregnancies and contraception use.⁸⁵ The guidelines state that it is for the

75. U.K. YOUTH PARLIAMENT, *supra* note 69, at 4.

76. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 36.

77. *Id.* at 37.

78. Education Act, 1996, c. 56, § 405. The national curriculum, which does not include SRE, consists of Math, English and Sciences, which are all statutory subjects. *Id.* at § 354.

79. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 39.

80. *Id.* at 38.

81. *Id.*

82. *Id.* at 39.

83. *Id.*

84. See KONTULA, *supra* note 15, at 62, 65; SOCIAL EXCLUSION UNIT, *supra* note 3, at 39.

85. DEPARTMENT FOR EDUCATION AND EMPLOYMENT, *supra* note 60, at 5.

schools, in consultation with parents, to determine the content of sex education⁸⁶ and that policies should be developed that “reflect the parents’ wishes and the community they serve.”⁸⁷ The students’ views should be considered when setting policy for SRE, but not when setting its actual content.⁸⁸ The guidelines, however, do not acknowledge the necessity of considering the students’ needs and interests.⁸⁹ Most problematic, the guidelines fall short of requiring schools to provide any specific information.⁹⁰ For example, in relation to abortion, the guidelines state that religious views should be respected, that schools are entitled to teach abortion in light of their religious convictions, and that SRE should enable students to consider the moral and personal issues involved in abortion.⁹¹ Clearly, the guidelines are not explicit about what needs to be covered to ensure that students have access to practical information about abortion. In fact, the guidelines’ preferred approach to reducing unwanted pregnancy is through “advice on contraception and delaying sexual activity.”⁹² A pregnant teenager, however, will need information about abortion if she is to make an informed choice about her pregnancy. In failing to address this aspect of the issue, the guidelines make a value judgment about the importance of delaying sexual activity. Meanwhile, the Sexual Offences Act 2003, which came into force on May 1, 2004,⁹³ decriminalizes sexual activity between those under eighteen.⁹⁴ While the U.K. government has relaxed legal constraints on teenage sex, it is failing to provide information on safe and responsible sex.

It is perhaps unsurprising then that the guidelines have not had the effect of reducing teenage pregnancy as per the government’s own target. As a result, in its last report, the Independent Advisory Group on Teenage Pregnancy recommended (for the fifth time) that sex education should be made a statutory subject.⁹⁵ Making it a statutory subject would allow the U.K. government to create a standard national curriculum, to include the information necessary to ensure that children and teenagers are able to make informed choices about sex, and to force its implementation in schools.⁹⁶ It would also prevent parents from withdrawing their

86. *Id.* at 4.

87. *Id.* at 4.

88. *Id.* at 7.

89. *See generally id.*

90. *See generally id.*

91. *Id.* at 16.

92. *Id.*

93. Sexual Offences Act, 2003, c. 42, § 9 (Eng.).

94. *Id.*

95. TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, *supra* note 22, at 22.

96. Education Act, 1996, c. 56, § 354 (Eng.).

children from sex education classes and ensure that teachers are trained to teach the subjects covered; thus, increasing the program's effectiveness and allowing OFSTED to monitor and evaluate their work. In short, it would ensure that all children receive quality standardized sexual health education.⁹⁷

In October 2008, in response to a report by the Sex and Education Review Steering Group, the government indicated that "it is attracted to giving" PSHE statutory status, thereby improving the delivery of SRE in schools.⁹⁸ It commissioned a further report to make recommendations as to how to incorporate SRE as a statutory subject. The report, however, must include information on how to "ensure that statutory programs of study" retain "sufficient flexibility for individual schools to tailor their PSHE and teaching to take account of their pupils' and parents' views and to reflect the ethos of the school."⁹⁹ On November 5, 2009, the government announced its plans to make PSHE part of the statutory curriculum by September 2011. However, the government reiterated its view that schools should be able to tailor their curriculum. It furthered recognized that a small minority of parents should be entitled to withdraw their children from select courses. The impact of making PHSE a statutory subject will be nullified if parents and schools are still able to impose their views on the content of sex education.¹⁰⁰ The government's commitment is, therefore, tempered by its intent to continue to allow schools to determine the content of sex education. Thus, mandatory sexual health education remains elusive in practice.

II. THE UNITED KINGDOM'S INTERNATIONAL OBLIGATIONS.

A. The International Covenant on Economic, Social and Cultural Rights ("ICESCR")

On May 20, 1976, the U.K. ratified¹⁰¹ the ICESCR, pursuant to which it is obliged to "take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realizations of the

97. TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, *supra* note 22, at 23.

98. DEPARTMENT FOR CHILDREN, SCHOOLS AND FAMILIES, GOVERNMENT RESPONSE TO THE SEX AND RELATIONSHIP EDUCATION (SRE) REVIEW STEERING GROUP 4 (2008), *available at* http://www.teachernet.gov.uk/_doc/13030/7924-DCSF-Sex%20and%20Relationships%20A4.pdf.

99. *Id.* at 5.

100. Press Release, Dep't for Children, Sch. and Families, *supra* note 70.

101. Letter from Dr. Peter Hall, Chair, Doctor for Human Rights, to Rt. Hon. Patricia Hewitt MP, Secretary of State for Health (Oct. 2, 2006), *available at* <http://phall.members.gn.apc.org/LtrSecStateAsySe.pdf>.

rights”¹⁰² enumerated in the covenant. Among the enumerated rights, is the right to health that is defined in Article 12 as the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹⁰³ In order to achieve the full realization of this right, States must take steps necessary to the “healthy development of the child.”¹⁰⁴ In General Comment 14, the Committee on Economic, Social and Cultural Rights (“CESCR”) further defined the right to health as inclusive of not only appropriate healthcare but also “the underlying determinants of health, such as . . . access to health-related education and information, including on sexual and reproductive health.”¹⁰⁵ This also includes measures to improve sexual and reproductive health services, including “access to information as well as to resources necessary to act on that information.”¹⁰⁶ The Special Rapporteur on Health states that traditional views about sexuality are damaging to adolescents’ sexual health and impede access to information about sexual health.¹⁰⁷

In addition, the right to health encompasses freedoms and entitlements.¹⁰⁸ The freedoms include the “right to control one’s health and body, including sexual and reproductive freedoms.”¹⁰⁹ The entitlements include availability of services, accessibility, acceptability, and quality health care.¹¹⁰ In the context of sex education, under the rubric of accessibility, the States are obligated to ensure the accessibility of information and the “right to seek, receive[,] and impart information.”¹¹¹ Without access to information there can be no freedom to exercise the right to control one’s body because the withholding of information limits choices and options regarding one’s sexual health.

Further, the States’ obligations can be divided into three categories—the duties to respect, protect, and fulfill. Under the duty to respect, the

102. International Covenant on Economic, Social and Cultural Rights, *adopted Dec. 16, 1966*, 993 U.N.T.S 5, art. (2)(1), 3.

103. *Id.* at art. 12(1).

104. *Id.* at art.12(2)(a).

105. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, ¶ 11, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter Comment on the Right Health].

106. *Id.* at ¶ 14.

107. U.N. Econ. & Soc. Council [ECOSOC], Comm’n on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶ 14, U.N. Doc E/CN.4/2004/49 (Feb. 16, 2004) (prepared by Paul Hunt).

108. Comment on the Right Health, *supra* note 105 at ¶¶ 8–12.

109. *Id.* at ¶ 8.

110. *Id.* at ¶ 12.

111. *Id.*

state should not limit access to contraception or other means of maintaining sexual health, including by “censoring, withholding[,] or intentionally misrepresenting health-related information, including sexual education.”¹¹² The U.K. is failing in relation to this obligation because it is willfully allowing some schools to avoid teaching sex education, or to teach it without providing children with all the necessary information. In addition, allowing parents to withdraw their children from sex education limits their access to information.

Under the obligation to protect, a State must enact legislation or other measures to ensure “equal access to health care and health related services States should also ensure that third parties do not limit people’s access to health related information.”¹¹³ By allowing schools to determine the content of sex education, the U.K. is not ensuring that all children have equal access to information about sex. Lack of uniform curricula inevitably results in subpar sexual health education. In addition, the government is allowing parents to limit children’s access to information.

Further, the obligation to fulfill requires a State to take positive measures to help its citizens realize their right to health. This includes “supporting people in making informed choices about their health.”¹¹⁴ By not taking positive measures to ensure that all children have access to sex education, the U.K. is failing to fulfill its duty. The U.K. is effectively inhibiting teenagers’ access to the information they need in order to make informed choices about sexual behavior and pregnancy. In sum, the U.K. has to do more to comply with its three duties—to respect, protect, and fulfill—pursuant to its international obligations under the ICESCR.

The U.K. may also be violating its obligations under the ICESCR if it does not use the “maximum of its available resources for the realization of the right to health.”¹¹⁵ Initially, a State has a duty to ensure a minimum core standard to ensure the right to health.¹¹⁶ The minimum core includes basic healthcare,¹¹⁷ which the U.K. amply provides as healthcare is free and universal in England. The State’s duty regarding the right to health does not cease once it complies with its minimum core obligations. The State has a duty to proactively facilitate the people’s realization of the right to health.¹¹⁸ State parties “have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full rea-

112. *Id.* at ¶ 34.

113. *Id.* at ¶ 35.

114. *Id.* at ¶ 36.

115. *Id.* at ¶ 37.

116. *Id.* at ¶ 43.

117. *Id.*

118. *Id.* at ¶ 31.

lization of Article 12.”¹¹⁹ This means that until the U.K. complies with its obligations under Article 12 as described above, the U.K. is in violation of the ICESCR.

Of course, a State agency could still try to argue that it does not have the means to comply with these obligations, but, in the case of the U.K., this argument is unlikely to resonate with the CESCR. In fact, CESCR has consistently stated in its reports regarding the U.K. that there is nothing preventing the U.K. from complying with its obligations under the ICESCR.¹²⁰ In the U.K., the failure to address the teenage sexual health issue is not due to a lack of funds, but rather, a lack of political will. This is especially evident from the government’s newest proposal that has failed to prevent schools from deciding individually on the content of sex education; therefore, failing to ensure that all children receive adequate, and uniform sexual health education.¹²¹ The U.K. advisory group has repeatedly urged the government to make SRE a statutory subject,¹²² yet it has failed to do so. The newest proposals would make PHSE statutory but they would exclude SRE; meanwhile, the effectiveness of PHSE at this point is uncertain.¹²³ Despite these new proposals, schools may still separately determine the content of their sex education.¹²⁴ It, therefore, cannot be said that the U.K. is progressing expeditiously and effectively toward the full realization of the right to health.

Parallel to the obligations in relation to the right to health, the U.K. has a duty to “ensure the equal rights of all men and women to the enjoyment of all economic, social[,] and cultural rights.”¹²⁵ Article 2(2) also provides for the enjoyment of these rights without discrimination on the basis of sex.¹²⁶ The CESCR has interpreted this to mean that men and women must enjoy the rights in the ICESCR on a substantively equal basis and that existing laws must “alleviate, the inherent disadvantages

119. *Id.*

120. See U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: United Kingdom of Great Britain and Northern Ireland*, ¶ 10, U.N. Doc. E/C.12/1/Add.79 (June 5, 2002); U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: United Kingdom of Great Britain and Northern Ireland*, ¶ 8, U.N. Doc. E/C.12/1/Add.19 (Dec. 12, 1997).

121. U.K. YOUTH PARLIAMENT, *supra* note 69, at 7.

122. TEENAGE PREGNANCY INDEPENDENT ADVISORY GROUP, *supra* note 22, at 22.

123. *Id.*

124. Press Release, Dep’t for Children, Sch. and Families, *supra* note 70.

125. International Covenant on Economic, Social and Cultural Rights, *supra* note 102, at art. 3.

126. *Id.* at art 2(2).

that particular groups experience.”¹²⁷ The obligation of State parties, therefore, is to ensure that men and women enjoy equal rights under the ICESCR in practice.¹²⁸

States’ Article 2(2) obligations are further divided into the duty to respect, protect, and fulfill.¹²⁹ Regarding the duty to respect, a State must consider the impact of gender neutral laws and policies and “whether they could result in a negative impact on the ability of men and women to enjoy their human rights on a basis of equality.”¹³⁰ Of course, pregnancy affects women differently than men. Women bear the burden of the physical impact. In addition, responsibility for nursing and early child rearing often lies with the woman.¹³¹ In relation to teenagers, it is generally the young mother who ends up the single parent, not the young father.¹³²

Thus, the teenage mothers endure the greater share of a pregnancy’s consequences. Pregnancy will, for example, restrict a mother’s ability to go to school and limit her vocational options for the future. A study has shown that a 33-year-old woman who was a teenage mother is more likely to lack professional qualifications and rely on state benefits than a 33-year-old woman who was not.¹³³ Accordingly, in failing to deal with the problem of teenage pregnancy through the introduction of mandatory sex education, the U.K. is discriminating against girls and women as they are predominantly affected by lack of information.

B. The Convention on the Elimination of All Forms of Discrimination Against Women (“CEDAW”)

The U.K. ratified The Convention on the Elimination of All Forms of Discrimination Against Women (the “CEDAW”) on April 7, 1986.¹³⁴ The U.K. acceded to the optional protocol on December 17, 2004, there-

127. U.N. Econ. & Soc. Council [ECOSOC], The Comm. on Econ., Soc. & Cultural Rights, *General Comment 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights*, ¶ 7, U.N. Doc. E/C.12/2005/4 (Aug. 11, 2005).

128. *Id.* at ¶ 6.

129. *Id.* at ¶ 17.

130. *Id.* at ¶ 18.

131. REBECCA J. COOK, BERNARD M. DICKENS & MAHMOUD F. FATHALLA, *REPRODUCTIVE HEALTH AND HUMAN RIGHTS* 15 (2003).

132. See generally John Hobcraft & Kathleen Kiernan, *Childhood Poverty, Early Motherhood and Adult Social Exclusion*, 52 BRIT. J. SOC. 495, 495 (1999).

133. See SOCIAL EXCLUSION UNIT, *supra* note 3, at 64 (90 percent of teenage mothers are in receipt of income support).

134. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 [hereinafter Convention on Elimination of Discrimination].

by allowing individual petitions.¹³⁵ Although the jurisprudence of the Committee on the Elimination of Discrimination Against Women (the “Committee on Discrimination”) does not speak to sex education, CEDAW protects the right to health, specifically, the right of “access to health care services, including those related to family planning.”¹³⁶ In its General Recommendation 24, the Committee defines the right to health for women.¹³⁷ While slightly different from those in the CESCRC, the proposals found in General Recommendation 24 similarly separate the right into obligations to respect, protect, and fulfill.¹³⁸ The obligation to respect “requires state parties to refrain from obstructing action taken by women in pursuit of their health goals.”¹³⁹ By failing to confront schools that do not provide sex education, the U.K. is arguably obstructing girls and young women from accessing information to make decisions about their health.

The obligation to protect “requires state parties, their agents[,] and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations.”¹⁴⁰ Although the examples given by the Committee on Discrimination relate to violence against women, it could be argued that a school without sex education is violating the right of women to make decisions about their health (as per the obligation to respect). Thus, to comply, the U.K. must implement a policy requiring such schools to provide sexual health education. In addition, the duty to fulfill is the duty “to take appropriate legislative, judicial, administrative, budgetary, economic[,] and other measures to the maximum extent of their available resources to ensure that women realize their right to health care.”¹⁴¹ If teenagers are not educated about available sexual health options, they are unable to make informed decisions about sexual health. Thus, by failing to legislate for mandatory sex education, the U.K. is preventing women from realizing their right to health.

The Committee on Discrimination also states that parties should “ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed pro-

135. Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Dec. 10, 1999, 2131 U.N.T.S. 83.

136. Convention on Elimination of Discrimination, *supra* note 134, at art. 12,

137. Report of the Committee on the Elimination of Discrimination Against Women, *supra* note 27, pt. 1, at 4, ¶ 14.

138. *Id.* at ¶ 24.

139. *Id.* at ¶ 14.

140. *Id.* at ¶ 15.

141. *Id.* at ¶ 17.

grams that respect their right to privacy and confidentiality.”¹⁴² Specifically, the Committee on Discrimination recommends that states “prioritize the prevention of unwanted pregnancy through family planning and sex education.”¹⁴³ In its 1999 report to State parties, the Committee on Discrimination voiced serious concerns about teenage pregnancy in the U.K. and recommended that it be addressed through various measures, including sex education.¹⁴⁴ As noted above, the U.K. is not limited economically. If anything, sexual health education is likely to lead to healthier teens and fewer teenage pregnancies, which in turn lead to longterm economic benefits. The U.K. domestic political climate is the only thing that inhibits the government from introducing sexual health education. Thus, by not making sexual health education mandatory, the U.K. is in violation of CEDAW Article 12.

In addition, CEDAW prohibits discrimination in law, or actions that have a discriminatory effect against women.¹⁴⁵ Thus, member states are required to take “all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men.”¹⁴⁶ As noted above regarding the ICESCR, the U.K. is in effect discriminating against girls because, in practice, they are adversely affected by the U.K.’s failure to make sex education mandatory. Girls, not boys, are getting pregnant and suffering the adverse consequences of teenage pregnancy. The U.K.’s sexual health policy is therefore discriminatory in practice against girls because they are not given access to information they need to make decisions about their sexual health. The choices girls make about sexuality have a greater impact on them than choices made by boys because of the possibility of pregnancy.

C. The Convention on the Rights of the Child (“CRC”)

The United Kingdom ratified the Convention on the Rights of the Child (“CRC”) on December 16, 1991.¹⁴⁷ Article 24 of the CRC recog-

142. *Id.* at ¶ 18.

143. *Id.* at ¶ 31.

144. See Comm. on the Elimination of Discrimination Against Women, *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: United Kingdom of Great Britain and Northern Ireland*, ¶ 289, U.N. Doc. CEDAW/C/UK/CO/6 (July 18, 2008).

145. Convention on Elimination of Discrimination, *supra* note 134, at art. 2(d)(e)(f).

146. *Id.* at art.3.

147. Convention on the Rights of the Child, *adopted* Nov. 20, 1989, 1577 U.N.T.S. 3, art. 24(2)(f).

nizes the right of children to the highest attainable standard of health.¹⁴⁸ This includes an obligation on the part of states to “take appropriate measures . . . to develop . . . family planning education and services.”¹⁴⁹ Moreover, public and private actors must primarily consider the best interest of a child in setting policy objectives.¹⁵⁰ According to Article 12, children should be consulted on matters that affect them, and their views should be “given due weight in accordance with the maturity and age of the child.”¹⁵¹ The primacy of a child’s rights is tempered by the State’s obligations to ensure that the protection and care given to a child “is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her”¹⁵² In addition, “State parties shall respect the responsibilities, rights[,] and duties of parents . . . to provide in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present convention.”¹⁵³ Thus, teenage mothers enjoy the Article 12 protections.

The Committee on the Rights of the Child has reiterated the right of adolescents to access appropriate information “essential for their health and development and for their ability to participate meaningfully in society,”¹⁵⁴ including “access to sexual and reproductive information, . . . on family planning and contraceptives, [and] the dangers of early pregnancy.”¹⁵⁵ State parties are further urged to address issues surrounding cultural and other taboos about adolescent sexual activity.¹⁵⁶ Finally, the Committee on the Rights of the Child has stated that adolescent girls “should have access to information on the harm that . . . early pregnancy can cause.”¹⁵⁷

The nature of the U.K.’s obligations under the CRC is different than under the other treaties. As noted above, the CRC recognizes the right to family planning education for children as a part of their right to health. Although parents retain some control over their children’s sexual health,

148. *Id.*

149. *Id.*

150. *Id.* at art. 3(1).

151. *Id.* at art. 12(1).

152. *Id.* at art. 3(2).

153. *Id.* at art. 5.

154. Comm. on the Rights of the Child, *General Comment No.4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, ¶ 26, U.N. Doc. CRC/GC/2003/4 (July 1, 2003) [hereinafter General Comment No. 4].

155. *Id.* at ¶ 28.

156. *Id.* at ¶ 30.

157. *Id.* at ¶ 31.

the notion of evolving capacity limits parental rights insofar as the control they exercise may be extinguished if the child has the capacity to make decisions on her own.¹⁵⁸ Therefore, at some point, parents may no longer be allowed to exercise this control over their children.¹⁵⁹ The age at which this happens clearly depends on the child. However, if the child is mature enough then she should be entitled to information even if her parents disagree. In fact, a teenager who is sexually active and requests information to prevent pregnancy is arguably more mature than one who does not seek the information.¹⁶⁰

The Committee on the Rights of the Child recognized this when it stated that adolescents should be allowed to express their opinions and have them be taken into consideration in relation to the right to health.¹⁶¹ In allowing parents to take children out of sex education and to determine with the school the content of sex education, the U.K. is violating the right of children to be consulted in these matters and to have their opinions heard. In 1995, the report from the Committee on the Rights of the Child to the U.K. government raised concerns about the right of a parent to take her child out of sex education without considering the child's opinion.¹⁶² It suggested that more should be done to ensure the incorporation of the views of children in decision-making that affects them.¹⁶³ In 2002, and again in 2008, the Committee on the Rights of the Child recommended that the State take further steps to reduce teenage pregnancy by making sex education part of the national curriculum.¹⁶⁴ Echoing many others before it, the Committee expressed concern that children were not being consulted about educational matters that affect them.¹⁶⁵ A 2007 survey showed that 73% of children age eleven to eigh-

158. Bernard M. Dickens & Rebecca J. Cook, *Adolescents and Consent to Treatment*, 89 INT'L J. OF GYNECOLOGY & OBSTETRICS 179, 181 (2005).

159. *See id.*

160. *Id.* at 182.

161. General Comment No. 4, *supra* at note 154, at ¶ 8.

162. Comm. on the Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland*, ¶ 14, U.N. Doc. CRC/C/15/Add.34 (Feb. 15, 1995) [hereinafter *Concluding Observations of 1995*].

163. *Id.* at ¶ 27.

164. *See* Comm. on the Rights of the Child, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 44, U.N. Doc. CRC/C/15/Add.188 (Oct. 9, 2002) [hereinafter *Concluding Observations of 2002*]; Comm. on the Rights of the Child, *Concluding Observations: United Kingdom of Great Britain and Northern Ireland*, ¶ 61, U.N. Doc. CRC/C/GBR/CO/4 (Oct. 20, 2008) [hereinafter *Concluding Observations of 2008*].

165. *See* *Concluding Observations of 2002*, *supra* note 164, at ¶ 29; *Concluding Observations of 2008*, *supra* note 164, at ¶ 32.

teen wanted SRE to be taught to those under thirteen.¹⁶⁶ This shows that children want SRE. By not ensuring that it is taught, the U.K. is violating its international obligations in relation to the right to health as well as its duty to take into account the best interests of the child and to give due weight to children's views.

Furthermore, the U.K.'s above-mentioned obligations must be read in conjunction with Article 2, which says that states shall respect and ensure the rights set out in the CRC "without discrimination of any kind, irrespective of the child's[,] or his or her parent's or legal guardian's[,] . . . religion[,] political [views][,] or other opinion."¹⁶⁷ This obligation is further laid out in Article 2(2), which says that member states "shall take all appropriate measures to ensure that the child is protected against all forms of discrimination . . . on the basis of the . . . expressed opinions, or beliefs of the child's parents, legal guardians, or other individuals legally responsible for him or her" ¹⁶⁸ By allowing parents control over the attendance of their children in sex education and its curriculum, the U.K. is discriminating among children based on their parents' views. Specifically, discrimination occurs when a child's parents, for religious or other reasons, are allowed to decide that the child is not to have access to information that her peers have accessed.

In addition, discrimination occurs between children in different schools.¹⁶⁹ As parents and schools are allowed to determine the sex education curriculum, children throughout England are given different information and some may get more complete and accurate information than others.¹⁷⁰ This discriminates between children in different schools on the basis of their parents' views. These two examples may lead to a situation where a teenager may want to access information about sex education because she is sexually active but is prevented from accessing it because of her parent's beliefs. She will then be disadvantaged compared to other children who have been given access to better information. In sum, as long as the U.K. fails to implement mandatory sex education, it is in violation of its international obligations under all three treaties. It is necessary now to look at the U.K.'s other international obligations, as well as its domestic law to see if implementing mandatory sex education contradicts those obligations.

166. U.K. YOUTH PARLIAMENT, *supra* note 69, at 7.

167. Convention on the Rights of the Child, *supra* note 147, at art. 2(1).

168. *Id.* at art. 2(2).

169. See Education Act, 1996, c. 56, § 403-05 (U.K.).

170. See *id.*

D. European and National Law

The European Court of Human Rights (“the Court”) has dealt with the issue of sex education under Article 2 of Protocol 1 (“P1-2”) of the European Convention on Human Rights and Fundamental Freedoms as part of the right to education and not as part of the right to health.¹⁷¹ Article 2 of P1-2 states, “[N]o person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the state shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions.”¹⁷²

The Court has held that parents’ rights under P1-2 must not conflict with the fundamental right of children to education.¹⁷³ Instead, the scope of the second sentence of P1-2 is to ensure that states convey information in “an objective, critical[,] and pluralistic manner.”¹⁷⁴ P1-2 prevents a State from pursuing “an aim of indoctrination that might be viewed as not respecting the parents’ religious and philosophical convictions.”¹⁷⁵ The European Commission of Human Rights has further stated that “parents may not refuse the right to education of a child on the basis of their convictions.”¹⁷⁶ The Court has also said that parents are not allowed to home school their children on the basis that they disagree with the content of the sex education curriculum due to their religious convictions,¹⁷⁷ and that a school was entitled to teach sex education.¹⁷⁸

There is no case law in the U.K. on the subject of sex education in schools and the rights of parents. There is, however, case law relating to corporal punishment. The House of Lords recently found that a statute prohibiting corporal punishment in schools was not in breach of P1-2.¹⁷⁹ Despite having to respect parents’ beliefs, Parliament was nonetheless entitled to decide that those beliefs validating institutional corporal pu-

171. Kjeldsen, Busk Madsen & Pedersen v. Denmark, 23 Eur. Ct. H.R. (ser. A) at 26 (1976).

172. Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms, *opened for signature* Apr. 11, 1950, 213 U.N.T.S. 221, art. 2.

173. Campbell & Cosans v. United Kingdom, 48 Eur. Ct. H.R. (ser. A) at 16 (1982).

174. Kjeldsen, 23 Eur. Ct. H.R. (ser. A) at 26.

175. *Id.*

176. Leuffen v Germany, App. No. 19844/92, Eur. Comm’n H.R., para. 1 (1992), *available at* http://www.echr.coe.int/echr/Homepage_EN.

177. Konrad v. Germany, Eur. Ct. H.R., para. 1 (2006), *available at* http://www.echr.coe.int/echr/Homepage_EN.

178. Alonso v. Spain, 2000-VI Eur. Ct. H.R. 477.

179. The Queen v. Sec’y of State for Educ. & Employment, [2005] 2 A.C. 246 [H.L.] (appeal taken from Eng.) (U.K.).

nishment were not in the best interest of the children.¹⁸⁰ In light of this jurisprudence, it is unlikely that European or U.K. courts would overturn the government's introduction of mandatory sex education in schools, as it would likely be deemed to be in the best interest of the children.

CONCLUSION

In summary, if the U.K. continues to allow individual schools and parents to determine the content of sex education and to allow parents to exercise control over whether their children receive sexual health education, the government will continue to fail to fulfill its obligations under the ICESCR, CEDAW, and CRC. The U.K. should introduce mandatory and adequate sex education in schools.¹⁸¹ This is not to say that if the U.K. introduces such measures, it would immediately be in compliance with its obligations. However, the U.K. cannot comply with its international obligations regarding the right to health until it introduces sex education, as this may go some way toward alleviating the problem of teenage pregnancy. Furthermore, the U.K. is in violation of its obligations under all three treaties because the government effectively discriminates between boys and girls, and among children generally on the basis of their parents' views.

As noted above, there are no reasons preventing the government from introducing mandatory sex education—the problem is one of political will. Introducing mandatory sex education would not require an overhaul of the education system. There is already a framework for teaching sexual health and relationship education within PHSE.¹⁸² What is required is the creation of a national curriculum for sexual health education that includes information about practical issues surrounding sexual health, including contraception, abortion, and prevention of sexually transmitted diseases. This would further entail training teachers in this particular

180. *Id.*

181. Even the most recent proposals do not go far enough in dealing with these issues because the fundamental problems of allowing individual schools to determine the content of sex education and allowing parents to remove their children out of sex education remain.

182. Press Release, Dep't for Children, Sch. and Families, *supra* note 70.

subject and making this subject a part of the national inspection program to ensure that schools are teaching the topic in accordance with the proposed national curriculum. It would also require isolating parents from decisions regarding sexual health education curriculum and children's participation in sex education. Without adequate information, children are unable to make informed choices about sexual health. And the right to health is fundamental.