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# RESEARCH AND EDUCATIONAL POTENTIAL OF FEMINIST CARE ETHICS IN SEX EDUCATION[1]

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**Abstract:** In this article, we interpret sex education from the perspective of feminist care ethics, emphasizing the concept of caring democracy, advanced by Joan Tronto one of the most influential feminist political theorists. According to Tronto, these theories show that a deficit of care and a lack of democracy are mutually conducive. We argue that, as in other areas of life, a lack of care in sexuality and sex education leads to social inequalities that eventually translate into an unequal approach to freedom, equality, and justice, and to a deficit of democracy in the lives of some people. At the same time, we believe that, as a moral theory, care ethics, with its emphasis on the needs of men and women, can be adequately applied to the design of research projects, as well as to sexuality policies and practices. This may contribute to overcoming the stalemate in the debate on sex education and other topics in Slovakia.

**Key words:** care ethics; sex education; democratic care; caring democracy; Joan Tronto; citizenship.

## Introductory

The current situation regarding sex education in Slovakia is complicated. The public discourse surrounding sex education can be described as mired in conflict or even as trench warfare. The dominant parties to this discourse subscribe to various schools of thought and concepts, namely the Christian tradition, the specialist medical and sex discourse, liberal (civic) dialogue, and discussions about HIV/AIDS (Lukšík & Supeková, 2003). They look to the concept of human rights to find support for their arguments regarding the form, content, and range of sex education. However, these tend to take on a foundationalist hue on all sides of the public discussion, limiting the potential for the implementation of human rights. This in turn can prevent the recognition and elimination of wrongdoing, pain, suffering, and injustice from the lives of individuals (Jesenková & Jesenko, 2015, pp. 41-58).

Care ethics is a weak normative moral theory that has the potential to avoid the pitfalls of foundationalism. With its emphasis on the context and specific experience (of those involved) and on supporting the principles, it moves dynamically between the empirical and

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normative levels, enabling a critical view and space for transformation on both levels, as well as providing resources for arguments of the antifoundationalist type. This means that it could open up space for joint values, and thus form the basis for shared communication, and ultimately for joint action in favour of the most vulnerable, for example, through the execution of their human rights.

We believe that ethics can, among other things, restore and develop real communication and dialogue between the groups involved.

It can focus the discussion on identifying and exploring the needs of those who benefit most from sex education; that is, the most vulnerable—children and young people. At the same time, care ethics allows us to understand the causes, factors, mechanisms, and processes that contribute to the formulation, content, and interpretation of educational practice concerning human sexuality, as well as to the marginalization or disregard for the needs of certain individuals and groups. Indeed, if the concept of human rights within sexual and reproductive health contains the moral solution to historical oppression in its various forms and can empower and protect those who are vulnerable to oppression, care ethics may constitute an adjunct through which human rights can become effective and practicable, so that social resources can be mobilized to protect the vulnerable. Therefore, care ethics can be understood as a starting point and support for the implementation of human rights.[2]

However, we believe that care ethics can act as a useful tool from a number of perspectives.

1. As *an analytical tool* offering multiple concepts (e.g. concept of care as a political, social and moral practice, concept of a deficit of care as associated with democracy deficits); it enables us *to better understand the situation we found ourselves in*, when dealing with sex education.
2. As a *normative tool* it enables us—through the ideal of the integrity of good care practice (elaborated by J. Tronto & B. Fisher (1990))—*to assess the practice of sex education* from the ethical point of view, looking at the extent to which it is a good (quality) practice that contributes to the good life of those engaging in it.
3. *It is an instrument for reformulating and improving public policy* in specific areas, especially education relating to sexuality, sexual relations and sex life—that enables a critical analysis of the specific practice(s) of care at the organizational and institutional levels in the relevant area of care practice (the teaching of sex education in the school system in Slovakia), which could provide the basis for revisiting the recommendations aimed at achieving the desired (social, political and moral) change.

We consider care ethics to be a particularly useful tool in sex education practice.

1. Care ethics focuses *on the private sphere*, with which both care and sexuality have traditionally been inherently connected, as part of the dimension of intimacy and love. Discussions have arisen as part of the theoretical work on care ethics as a political and moral theory that question the traditional substantialism in understandings of the

[2] For more on the relationship between care ethics and justice ethics, and for the relationship between care, justice, and the law, see Jesenková (2016, pp. 77-79).

public and private spheres, and of public and private life. Arguments in care ethics have *favoured opening and critically reflecting upon the boundaries between the public and private spheres, and of shifting care away from the exclusive confines of the private sphere*. This approach may be constructive in the critical analysis of intimacy, sexuality and love, and in the subsequent re-conceptualization of these key categories in sex education.

2. Care ethics is *based in relationistic ontology* which allows for a relationistic (relationship) understanding of autonomy and for *vulnerability to be seen as an essential part of the lives* of all human beings, and other species as well. This enhances both the importance of *teaching social responsibility* in the ethics of intimate and sexual relations and the importance of active citizenship in applying and respecting human rights in, for instance, sexual and reproductive health
3. Care ethics allows us to look at *sex education as a source of care*. Here, it means drawing attention to the fair distribution of this resource and its availability to all who need it. Access to sex education provides an opportunity for a good life, both in personal relationships and in the public sphere as full citizens.
4. Through care ethics *the teaching of sex education can be seen as a moral, social and political practice*, in its (distinct) unity. The focus is therefore not just on the responsibility of those implementing it (teachers, experts, school managers) but also on *creating the systemic (structural) conditions for good quality sex education* (the material conditions, staff, professionally qualified teaching, organizational quality, etc.). There is an increasingly urgent need for social responsibility (in care). The ethics of care has the potential to improve sex education both by transforming its content (re-conceptualization of concepts, categories and relationships between them) and the form and method of teaching. In terms of content, it can significantly contribute to changing understanding on many key concepts in sex education, such as sexuality, intimacy, love and (personal and public) relationships. This is a consequence of the conceptual reconstruction of the conceptual domains on the meta level that has traditionally connected the concepts of the private, personal, public and political, as well as citizenship, the social, the home and the family, including the non-substantivist, non-socialist and non-dichotomous reformulation of relations. On the formal level the transformation has mainly been in relation to how sex education should be taught given the pluralism, inequality and vulnerability of individuals in some classes and groups. This relates to educational methods and pedagogical approaches, as well as the need for highly trained experts who are not only competent but also capable of creating a safe space for confidential relationships. It is also a question of those with responsibility for schooling (local government, the state, church) creating the systemic conditions for sex education, and working alongside families and parents, communities and local communities as well as society as a whole.

The application of ethics of care in a particular field, in a specific historical, political and socio-cultural context, can be beneficial not only for those who are part of this context. It can be useful not only for those who are involved in different ways in a particular care practice (sex education) in the field investigated. Research on care ethics can show how normative frameworks, cultural patterns and social imagination determine how and whether global

processes and tendencies are integrated within a particular practice of care in a specific context. It can encourage the investigation of the different ways in which practice and care relationships are shaped, reproduced and modified and of the strategies used. It can inspire us to explore how individuals and groups cope with the de facto practice of care and how they strive to practice good care that allows all those involved to live a good life. From the perspective of care ethics, this means focusing on the processes and factors involved in the democratization of relationships and care practices in specific contexts and conditions. Ultimately, it can contribute to formulating strategies on how to improve the practice of care in terms of democratization and on a global level.

## Care ethics as a moral perspective and theory

Although care ethics has barely been in the spotlight of philosophical thought for more than half a century, it has undergone dynamic development since its inception in the 1980s. Starting from the first generation of theorists (Gilligan, 1982, 2001; Ruddick, 1980; Noddings, 1984) who looked at relationships of care as personal dyadic relationships in the private sphere, through to Virginia Held's work, and ending with the work of the second generation of care ethics theorists today.

The second generation of care ethics has shifted towards political care ethics, as conceived by many contemporary philosophers and social scientists, such as Joan Tronto, Selma Sevenhuijsen, Marian Barnes, Eva Feder Kittay, Maurice Hamington, Daniel Engster, Fiona Robinson (Jesenková, 2016). This shift in care ethics—from a moral theory of private intimate relationships to a political theory dealing with public life and relationships on the one hand and from a theoretical description of relationships and care practices to an applied theory and applied care ethics on the other—has influenced the sociocultural and historical environment into which various care ethics concepts are introduced. For instance, in the USA the absence of social politics and a welfare state has led to a proliferation of theoretical work in care ethics and care ethics practice, but there is little work that applies the theoretical concepts of care ethics to practical politics and social services (Barnes, 2012). Conversely, in Europe, several important studies have been carried out that draw on the synergy between a sophisticated analysis of real social politics and a critical reimagining of the theory of care ethics (Sevenhuijsen, 1998; Barnes, 2012).

Currently, care ethics influences political analysis and social practices regarding, for instance, welfare, education, healthcare, and international relations. In this regard, several theorists have started using the phrase "socializing care" to refer to the theory and application of care ethics in public life. The concept of socializing care assumes that a carefully implemented care ethics can lead to a reimagining of institutions, politics, and social dynamics. This constitutes a paradigm shift that aids the deconstruction (not destruction) of the open, moveable border between the home and the community—between the public and private spheres (Hamington & Miller, 2006, xiii-xiv). Joan Tronto, who is one of the most important contemporary theorists of care ethics, considers the dichotomous gulf between the public and private spheres to be, at its root, a democratic deficit, as well as a care deficit, affecting post-industrial, post-capitalist societies (Tronto, 2013).

Fundamentally, care ethics is characterized by the following:[3]

1. A focus on the moral significance of attentiveness and acquiescence to the needs of those for whom we are responsible. In this regard, care ethics is often understood within the larger context of the ethics of responsibility, because the key question for a care ethicist is: "How can I be a responsible being?—How can I behave responsibly?" Selma Sevenhuijsen believes that above all care ethics approaches moral problems with a "sensitivity, responsibility, helpfulness, and a willingness to consider matters from various points of view." This approach to care often leads to practices that cater to the needs of the vulnerable. In fact, Sevenhuijsen characterizes the act of care as "the ability and willingness to 'see' and 'hear' the needs of others and take responsibility for fulfilling them." (Sevenhuijsen, 1998, p. 83)
2. A positive role for rationally evaluated and considered emotions in the epistemological process of our understanding of our moral obligations and of identifying the best course of action or way of life.
3. Acceptance of moral attachment to a particular person, as well as a sceptical attitude towards abstract, generalized moral rules, and their importance in all situations.
4. The reconceptualization of the traditional division between the public and private spheres, and their relationship to each other. As traditionally conceived of in the relationship between the public, political, and private, care is understood to be an exclusively private affair. If we place care in the realm of public activities, relationships, and processes as a relevant part of the political space, we must also cast doubt on, disrupt, shift, and renegotiate the borders between the public and private spheres of life (Tronto, 2013, p. xi).
5. The concept of autonomy in relationships: in care ethics, everyone exhibits a certain degree of dependence on others, and people are interdependent (Held, 2015, pp. 22-29).

In addition, the following characteristics can be found in more contemporary work on care ethics:

6. Vulnerability is inherent in all beings.
7. Care is always relational—it takes place within relationships and all of its phases have a relational component (Sevenhuijsen, 1998, p. 82).
8. Care is a practice, not simply a value, disposition, quality, or virtue (Sevenhuijsen, 1998; Tronto, 1993, 2013).
9. Care is a resource (Sevenhuijsen, 1998).

### Joan Tronto: Caring society, caring democracy and democratic care

In our research, we primarily rely on political care ethics as elaborated by Joan Tronto (1990, 1993, 2013, 2014). We agree with the vision of a caring and just society Tronto outlines. Therefore, in what follows we outline the concept of a caring society based on the practice

[3] For more on the individual characteristics of care ethics, and for the relativistic ontological and epistemological beginnings of care ethics, see Jesenková (2016).

of democratic care as the best form of care. These concepts are key to our research on sex education in the Slovak education system.

Joan Tronto and Berenice Fisher have produced the most widely accepted definition of care, which sees care as

> …a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web. (Tronto, 1993, p. 103)

Importantly, Tronto views care as an ever-present social, political, and emotional pursuit. That is, she believes that care cannot be reduced to a disposition or quality; rather, it is an activity that is fundamental to the preservation, maintenance, and development of human life. In practice, care always takes place within a specific context and under the conditions that conduce, structure, and form it. However, this also contributes to inequalities that can lead to social injustice.

In 1990,[4] Tronto, along with Berenice Fisher, identified four elements—values or moral principles[5]—of care. However, these elements do not constitute a specific set of practices or behaviors; rather, they provide a framework for evaluating whether given care practices are adequate within social politics and social work, and for guiding discussions with individuals in care relationships. Therefore, to achieve "integrated care", the practice of care must involve: attentiveness, responsibility, competence, and responsiveness. Indeed, Tronto identifies these elements (principles/values) in her analysis of the individual phases of care: (1) Caring about others, (2) Accepting responsibility for the care of others (taking care), (3) Providing and carrying out care (care giving), and finally (4) Accepting care (care receiving). The first phase requires attentiveness, awareness, and the admission that care is necessary. If this attentiveness to the needs of others (and oneself) is to occur, it must do so within the context of a relationship. In this regard, Tronto presents a relationistic understanding of human beings and their autonomy.

To recognize the need for care, a person must recognize their own and others' insufficiency, vulnerability, and mutual dependence. At the same time, as Tronto notes, our ability to identify needs and understand them is shaped by our social and cultural relationships, and by the context we find ourselves in. Thus, to cultivate the values of attentiveness, a person must be able to critically evaluate their cultural role models, as well as the social and political structure that shapes their perception of their needs and the needs of others. The second phase of the care process requires action—activity. That is, we must accept a specific responsibility to fulfill the need that we have become aware of. Tronto, like Sevenhuijsen, distinguishes between the concepts of responsibility and obligation in the context of care ethics.[6] The third and fourth phases show, in various ways, that a

[4] Fisher & Tronto (1990, pp. 36-54).

[5] M. Barnes uses the term "principles" to refer to Tronto's ethical elements (Barnes, 2012), while many others use the term "values".

[6] The concept of obligation in Tronto's view points to the existence of a formal duty, obligation, and agreement that is similar to that in a contract and in contractual relationships. She understands

consideration of the consequences of care giving is a necessary aspect of the practice of care. Competence comprises the demonstrably qualified work and activities of care, which are founded on certain knowledge and skills.

Therefore, it is not enough to simply identify the need for care and accept responsibility for providing it; we may fail to fulfill the needs of the care receiver due to a lack of expertise or skill. Of course, this can occur in both the private and public spheres, with care givers failing to achieve the goal of providing good quality care. A lack of responsiveness as a guiding principle or value can lead to inadequate care. Thus, we return to the attentiveness that began the process of care. This cycle comprises and completes the integrated care described by Tronto.

In her book *Caring Democracy* (2013), Tronto adds a fifth phase of care to the four already mentioned: *shared care (caring with)*, which is characterized by the principles and values of trust and solidarity. This fifth phase highlights the way in which the process of care repeats over time so that habits and patterns are formed, and trust and solidarity are built. Trust can grow when care givers adhere to reliable care practices. When people can reliably expect their needs to be met by either themselves or others, their trust in others grows and they start to feel that their relationships are characterized by solidarity. This phase is typical of democratic forms of care, which lead to equality. Thus, shared care is a necessary element of a caring society and a caring society can breed egalitarian shared care relationships and, in turn, a caring democracy, in which care takes place in a democratic manner.

So, the conception of a caring democracy is based on the following premises: (1) everyone both requires and provides care, and (2) the way in which care activities must be reassessed in all societies from both a philosophical and a political perspective (Tronto, 2014, p. 107). The concept of a *caring democracy* is based on two conditions: democracy must become more caring, and care should become more democratic. "Caring with" then requires the transformation of both current democratic caring practices and current democratic caring institutions (Tronto, 2013, p. 147).

According to Tronto *democratic care* is better care than nondemocratic (hegemonistic, i. e. paternalistic, maternalistic, parochialistic, or expertocratic) forms of care. She argues that: 1. care benefits from being done by more people (put simply—more eyes see more); 2. citizens who share a sense of common purpose with others are more likely to care for others, and are more likely to be better at caring for them; 3. insofar as democratic caring flattens hierarchies, it improves the quality of care; less hierarchical authority patterns are more likely to produce shared views, and those shared views are more likely to result in social capital and wise action (Tronto, 2013, pp. 156-157).

The democratic care must therefore be inclusive. This means that no one should be excluded from access to care as a source and from participating in decisions surrounding the responsibility for care. Therefore, we must also analyze—on an empirical level—the necessary responsibilities (for care) that grow out of a plurality of relationships and care practices, as well as the avoidance of such responsibility for care. Tronto refers to such

responsibility as a social or anthropological concept; responsibility manifests itself more in the realm of implicit cultural practices than in formal rules or a series of promises (Barnes, 2012, p. 21).

avoidance as "privileged irresponsibility." Individuals rid themselves of responsibility for care in various ways; in particular, they may justify their irresponsibility by appealing to the following priorities: (1) carrying out protection, (2) performing production, manufacturing, or work, (3) looking after their own interests, (4) personal responsibility, and finally (5) charity (Tronto, 2013, pp. 67-94).

Tronto criticizes neoliberal ideology and political practice for its emphasis on the independent autonomous subject with personal responsibility and for reducing everything to the private sphere. She considers it an obstacle to greater inclusion. Inclusion is only achievable when we admit that we are all care receivers. We must first realize that we are vulnerable and dependent beings before inclusion can become the basis of collective action (sharing responsibility). The human reality is that not everyone has sufficient resources to operate on their own. And Tronto even claims that, in fact, no one is likely to be able to function completely independently, which can be considered as the consistent application of relational ontology to the nature of human being (Tronto, 2013, pp. 144).

For everyone to become more caring requires the adoption of a moral framework that guards against the moral dangers of acting paternalistically—which reduces the freedom of others, and parochially - which makes equality more difficult to achieve (Tronto, 1993). So, neoliberalism, paternalism and parochialism are obstacles to establishing democratic care practices. The connection between a *care deficit and a democratic deficit is clearer now*. They are two sides of the same coin, and—as Tronto has argued—the root of both deficits lies in the dichotomous gulf between the public and private spheres. It is the source of the stigma associated with being a public care recipient. It also places pressure to relegate the forms and sources of care to the private sphere, and on the private sphere (family, market) to take responsibility for implementing different care practices. However, care that is separated/ segregated in this way does not produce good results. It is often damaging to individuals (recipients and providers), their relationships, and society as a whole.

The gap between the public and the private spheres prevents greater inclusion and thus prevents the participation of all the actors involved in establishing care practices, identifying and specifying the needs to be met, working out how it should be done, and determining responsibility for the performance of the individual activities that constitute care.

So what should caring institutions look like if they are to be capable of democratic, and therefore good, practice of care? According to Tronto, there are three elements or aspects of care which need to be consciously worked out in these institutions: (1) a clear account of power in the care relationship, which requires a politics of care at every level; (2) a way for care to remain particularistic and pluralistic; and (3) to have clear, defined, acceptable purposes of care (Tronto, 2013, p. 159). It is clear that a caring democratic institution must have developed mechanisms (and constantly improve them in interaction with carers) against the abuse of power in relationships and in the practice of care, and against the use of care for undesirable purposes. Likewise, caring institutions will have to improve their care practices if they are to identify, understand, and meet the specific needs of both care receivers and care givers in their activities and practices.

That is why interpreting the needs is an essential part of caring. Who should determine the needs of those who require care? Trying to define and specify needs is complicated. Tronto argues that regardless of the philosophical approach used to understand the needs,

the democratic practice of revisiting this question will be a key part of democratic caring practice.[7] Thus, we have some important criteria for investigating and evaluating institutions: How does the institution come to understand its needs? How does it negotiate its needs within itself? Which needs are taken as legitimate? Who actually gives the care? How is the reception and effectiveness of care work evaluated?

The democratization of care institutions is an important challenge for institutions traditionally seen as part of the public sphere, such as the school, and for institutions that are the traditional domain of care in the private sphere, such as the family.

The family was assumed to be a place of harmonious, stable, conflict-free relationships—ones founded on the love between children and parents, and on that between the parents themselves, and that had biological legitimation (through blood ties). The family order was founded on the paternal and patriarchal authority of the father/man. In traditional social and political theories, neither politics nor the law should interfere in the private sphere, as is illustrated by the well-known saying: "a man's home is his castle." Thus, it was understood that the family required no political interference or legal regulation and protection. However, care ethics, just like feminist ethics, shows that this was not only a mistake, but also an inappropriate, normative model. The traditional dichotomous perception of the relationship between the private and public spheres has obscured the fact that politics, law, and economics are part of private relationships. Decisions are made in the public space that affect personal relationships in private and in the family. Ignorance of this fact has allowed abuses of power within families to go unseen. In the same way, economic and social inequalities and injustices regarding the division of labor and responsibility for care have been marginalized.

One consequence of the traditional dichotomous conception of the public and private spheres, which is closely related to the dichotomous view of the relationship between power and love, and between power and care[8], is that intimacy and sexuality, as well as the relationships in which these dimensions of our lives are expressed, are pushed out of the public sphere of politics and law. This marginalization has led to a norm that, when applied to real life, has many negative consequences, such as weak protection of vulnerable individuals in intimate relationships, including relationships that are traditionally idealized and romanticized; namely, the relationship between parents and children, and between family members.

When considering the need for caring institutions to be turned into places of good, democratic care practice, thereby making them truly caring institutions, we inevitably need to critically think not only about school and its ability to provide good care, but also about the ability of the family to provide all the necessary care in the home. We believe that re-

[7] Tronto emphasized that care must be understand as an ongoing social process, not as an entity that can be granted to or withheld from citizens. It is not enough then to assert entitlement to care as if it were a good to be distributed. The role of the state then either supports or hinders the ongoing activities of care, and this has become a central part of the public debate (Tronto 2013, p. 154).

[8] For more on the dichotomous conception of the relationship between love and power, or that between care and power, see Jesenková (2016).

conceptualizing the home, which is such a key category in our understanding of private spaces, life, and relationships, is important in terms of its application in sex education.[9]

It turns out that in order to achieve the values of good and quality care, we need shared responsibility and care practices based on the principles of inclusion, not exclusion and privilege. What does this mean exactly and specifically for the Slovak context? How can it be achieved within the space for the public debate that is just emerging?

## Sex education from the perspective of care ethics

In many liberal democracies, progressive (not traditional) sex education follows a predominantly evidence-based approach. This approach has been used to draft, research, and support syllabuses that have effectively prevented the sexual transmission of diseases, pregnancy, and premature sexual relationships. The main priority is effectiveness in preventing health risks; other aims are marginalized in favour of this priority (Lamb & Randazzo, 2016, p. 148). Secondly progressive sex education targets the social aspects of sexuality and sex education. Thus it is a value-based educational program in which inclusive sexuality forms a large part.

The dominant strategy of political decision-making bodies in the US is to favour an educational approach that is founded on evidence and can provide statistics on its effectiveness. For this reason, a value-based education has been pushed into the background and, as Sharon Lamb points out, teaching focuses on prevention only, at least in the US. It is clear that focusing on health-based aims squeezes out other curricular themes that directly address ethics and social justice (Lamb & Randazzo, 2016, p. 149).

Sharon Lamb, who is an important figure and a proponent of ethics, and who would like to see care ethics once again form part of sex education syllabuses in the US, argues that focusing on health-related aims and effectiveness has led to the development of an egocentric ethic of sexuality that neglects questions relating to the ethical treatment of partners and values such as care and reciprocity. She claims that this self-centered viewpoint prepares students to make decisions about their own health, but that it excludes, or only marginally discusses, the issue of how other people should be treated; it also fails to mention young people's responsibilities with regards to sex and sexuality in society (Lamb & Randazzo,

[9] In this regard, the endeavors of Iris Marion Young have been particularly important. In her opinion, the concept of the home carries historical connotations of oppression and privilege. It also holds critical and emancipatory potential, because it expresses unique and purely human values (Young, 2010). Young claims that the home may have political significance as a place of both dignity and conflict. In addition, she asserts that, because the terms "have a home" and "be at home somewhere" imply privilege in today's world, the values of the home should be democratized and not rejected. The fundamental positive significance of the home lies in the fact that it gives meaning to our actions; it anchors and roots our unstable and fickle identities. These conceptions of the home do not set the public and private spheres against each other; rather, they describe the conditions under which the home can be included in the political and public discourse. In Young's view, the home represents at least four normative values that should be accessible to everyone: safety, individualization, privacy, and retention of identity. These values constitute regulatory ideals and standards for evaluating and criticizing contemporary society (Young, 2010).

2016, p. 149). Several scholars have described and characterized the current backdrop to sex education, namely its neoliberal context, which regards personal responsibility as the most important value (Bay-Cheng, 2012; Brown, 2003; Elliott, 2014; Apple, 2001).

M. Apple (2001) considers it problematic that in neoliberalism the ability to make a choice is described as a central democratic freedom, since most people do not have equal access or equal opportunities to make choices. Lamb and Randozza characterize neoliberalism as "hyper-individualism" that is founded in an economic neoliberal social context conducive to the sexualization of girls and the objectification of women (Lamb & Brown, 2006). In neoliberal discourse, there is a fundamental blindness to the social conditions within which individuals act and make decisions. However, until these basic conditions of inequality are addressed, gender, class, and racial inequality will not be considered in discussions about predatory or problematic behavior. Arguments about personal responsibility appear as an answer to problematic situations regarding sex, as well as to the question of who is guilty in situations of predatory behavior, and to the matter of social injustice (Lamb & Randazzo, 2016, p. 150).

Sharon Lamb, and others (Carmody, 2005), have argued for sex education syllabuses that emphasize not only choice and autonomy, but also the conditions under which these values can be realized (Lamb, 2013). Lamb considers care ethics, which can be understood as the standard for liberal justice ethics and complete equality, as especially suited to preventing harm in sexual relationships—particularly harm caused by predatory behavior. However, this would require sex education to be placed within a social context, and therefore involve a critical understanding of the standings of the various individuals (students and others) in the network/structure of social relationships. It would also require instruction to be placed within a value-laden ethical framework.

In the European and world context, care ethics constitutes a new, alternative and inspirational perspective in sex education. The key idea in care ethics is to help students think about matters they had previously perceived as exclusively personal within the context of society and social relationships. In some countries (the USA, New Zealand), progressive sex education of this kind contributes to the formation of an educational environment that sees sex education as a form of civic education. In Sharon Lamb's view, teaching sex education in this way supports efforts to eliminate violence in sexual relationships; it also sparks activism for media reform, for understanding the law around sexual consent, and for the ethical treatment of others. Similarly, it supports a curriculum in which sex education is part of democratic civic education. By using practical philosophy and/or ethics as a guide, sex education of this kind can also resolve the marginalization of certain social groups, tackle problematic stereotypes and confusing messages about sex and sexuality within society (Lamb & Randozzo, 2016, p. 164).

**Sex education in Slovakia**

In Slovakia, sex education has transitioned from gender education to sex education, and finally to education about marriage and parenthood. After 1989, compulsory syllabuses entitled "Sex Education" were introduced. Later, in 1994, these were updated and issued as separate syllabuses for the 1st and 2nd levels of elementary school and high school. However,

sex education did not have the status of an individual course, so syllabuses for sex education are intended for teaching in other subjects (ethics education, religious education, biology, physical education, etc.) and they are marked as cross-sectional. Later, for political reasons the syllabuses were renamed "Education for Marriage and Parenthood for Elementary and High School", but the content was not changed and they did not constitute a separate subject. In 2008, several sex education-related themes were integrated into the syllabuses of civic education, ethics, religious education, biology, and natural sciences. At the same time, the "Education for Marriage and Parenthood" syllabuses were updated.

From 2008 to 2010, these syllabuses were made compulsory for elementary and secondary schools and used across subjects; the individual themes were incorporated into the syllabuses of biology, civic education (social studies), and ethics/religious education. In 2010, the subject syllabuses were reclassified as non-compulsory, and teachers were given the added responsibility of discussing their planned themes with parents. Once the teachers had considered the parents' comments and discussed their plans with the methodology board, they submitted their plans to the principal for approval. In September 2015, an upgraded state education programme was introduced in Slovak schools. According to this programme, sex education, still called "Education for Marriage and Parenthood", again become a compulsory cross-sectional component taught across subjects at elementary and high schools. Nonetheless, the syllabuses have not changed in a long time.

In Slovakia, the ethical aspects of sex education are less widely discussed as part of social and gender politics. That said, in the discussions surrounding the "referendum on the family", which was held in Slovakia in February 2015, some commentators did touch on the ethics of the problem. However, no deeper analysis or argument was made. We would suggest that in Slovakia sex education is more concerned with discussions of human rights based on foundationalist and deductive arguments than on the real needs of children and young people as they perceive them.

Care ethics allows us to see sex education (amongst other things) in the Slovak education system as a care practice. It also enables us to evaluate this practice on the basis of the principles of the integrity of good care practice but, above all, on the basis of criteria for democratic care practice. It also allows us to view the undesirable phenomena related to sexual health, sexuality and intimate relationships—such as sexual violence, violence in partnerships and domestic violence, pregnancy at a young age among women in socially marginalized communities, sexism, the commodification of sexuality, body objectification, pornography—as a manifestation and consequence of a care deficit, closely linked to the deficit of democracy. The deficiency of care in sex education in Slovakia can be exacerbated by inadequate or non-existent access to sex education for all those who need it. This deficit can also be seen as an insufficiency, as a reflection of the poor quality of sex education practices - in form and/ or content—and as far from the ideal democratic practice of care. Finally, we can identify the nature of the care deficit in sex education in relation to the deficit of the democratic form of care by examining the structural conditions of the education system in Slovakia. We analyse the basic conceptual documents of general education policy and of sex education, which form the normative framework for education.

Based on an ethical and conceptual analysis of key education documents in the Slovak Republic (SEP—the State Education Program, EMP—Education for Marriage and

Parenthood syllabus) and an analysis of the education system, we argue that the conceptual framework and structural conditions are insufficient for sex education to be considered an example of democratic care practice, and that it does not contribute enough to democratic inclusion-based care nor, therefore, to a caring democracy and a more caring society. We consider the reproduction of the traditional division of activities and practices in the public and private spheres to be the cause of these deficits. While citizenship is about exercising one's own rights while respecting the rights of others, its constituent element—morals and values—concern the sociality of humans, which is seen as an aspect of interpersonal relations. Values and morals are not conceptualized in connection with citizenship, rights, and democracy. Teaching students to becoming decent, morally mature people and active citizens are two of the main goals of the Slovak education system, and these are conceptualized in different thematic areas of the SEP. Active citizenship, exercising one's rights, patriotism and democracy are taught in civic education. Morality, values, prosociability, sex education, education for marriage and parenthood are taught mainly in ethics education or religious education (either one or the other is compulsory).

The distinction between the public and private spheres is connected with the marginalization of care and the creation of meaning—questions about the creation, cultivation, and propagation of values. For this reason, child-rearing, education, and the cultivation of values are neglected.[10] This marginalization of the private world and activities that have taken place such as the creation and preservation of values can be perceived as concomitant with the development of a modern industrial society. Forty years of totalitarianism in Slovakia did not mean that general trends elsewhere were ignored, so values typically associated with the private sphere were pushed back into the private sphere out of the public space and public interest. One of the consequences of this process is the reluctance of private care institutions to allow other actors in the public world/sphere to participate in the creation and interpretation of things worth creating, preserving, and saving. The extent to which these values are linked to the sacred is questioned in these negotiations and struggles. In this case, because the value of care (the value of intimacy, sexuality, family, home, relationships etc.) may appear to be held in caring for the sacred, which can be interpreted as a vocation, and therefore privilege. It is clear that this view requires deeper exploration.

There is a tendency in the SEP and EMP for care to be seen in private terms. The concept of care is found in three contexts: 1. *In a healthy lifestyle context* (such as personal mental and physical health care, lifelong health care)—the concept of *personal responsibility*; 2. *in the biological and medical context* (caring for pregnant women and the foetus, caring for a newborn child)—the concept of expert responsibility (the competency of an expert is guaranteed by the state) and *state responsibility*; 3. *In the family life context* (traditionalist discourse)—parental care (parenting—nutrition and care) and maternal care (feeding,

[10] For more on care ethics in values and ethics education, see Klimková (2015). The absence and marginalization of teaching humanist and democratic values has led to many of the problems currently facing liberal democracies, such as the "values crisis", which, in the sociocultural and historical-political context of Slovakia, is related to the rise of radicalism and extremism among young people (although not exclusively), as well as lack of trust in democracy and its institutions.

changing diapers, washing, regular visits to the doctor), children caring for elderly parents - intergenerational solidarity—the concept of *family responsibility*.

In principle, care is either viewed in the sense of biological-reproductive activities performed within the private sphere, or activities that are performed as public health care. There is an absence of social/ collective responsibility in the sense Tronto uses ("caring with"). State or family responsibility cannot be identified as a social/ collective responsibility (in the sociocultural context of Slovakia) as both are associated with exclusion (of the power, care and responsibility of others), so these kinds of care are paternalistic and parochial, and hegemonic in character. As hegemons they claim the privilege of determining the needs of those for whom they are responsible.

The low measure of inclusion is the likely consequence of the separation of activities, care practices and responsibility for their implementation. It is clear that the education policy expressed in the strategic documents also reflects the socio-cultural context, cultural patterns and social imaginations, which form a value framework conditioning the formulation of specific documents. This means that if we want to change democratic care in sex education in Slovakia, we not only have to redraft these strategic documents but also to transform our value frameworks, beliefs and attitudes.

## Conclusion

Care ethics contains several inspirational ideas that could be applied in sex education. Indeed, from the perspective of care ethics, sex education must be seen as a form of care, and therefore as a source that is accessible to all vulnerable individuals who could use it to help create a safe environment in which they can shape their individuality (including the sexual dimension) and maintain their unique individual and social identity. In this way, sex education is a specific kind of care, an instrument for achieving a good life, with particular regard to the sexual dimension expressed in intimate relationships. However, this desired state, which we could call, using Tronto's terminology, democratic care in sex education, cannot be achieved unless it becomes a mutual, shared practice of care for a good life.

As long as a good life, with its sexual dimensions, remains exclusively a question of personal responsibility that is based on the concept of the atomized individual who exists independently of all relationships, and is situated in the private sphere of deepest intimacy, then the source of care, as well as the benefits that flow from it, will be inaccessible to certain people. These people may thus become disadvantaged and trapped in an unequal situation or relationship. Because of this deficit of care, they may be unable or limited in their ability to fully participate in the provision of care, the receipt of care, or the decisions around the division of responsibility for care. Their initial disadvantage in the receipt of care will, in time, accumulate and propagate, growing into a spiral of insufficient care from which it is difficult to escape.

Thus, adequate sex education must rely on a relationistic understanding of the person and of a personal autonomy that allows individuals to recognize and accept responsibility as part of a collective/society that fosters a good sex life for its members. That is, it is our social responsibility to share in the creation of a system that is conducive to such a life—for example by supporting and providing quality sex education.

Thus, sex education taught from the perspective of care ethics or democratic care can constitute part of a young person's preparation for fully-fledged citizenship, and for being able to fully, equally, freely, and fairly/justly take part in the division of responsibility for care as part of life in a democratic society.

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