

Wake up and smell the condoms, there's more to know than
abstinence:

*An Analysis of Sex Education Programs in the United States, the
Netherlands, France, and Germany*

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Abstract

The ability to control one's sexuality and make informed, responsible decisions about one's sexual health is a basic human right. The Netherlands, France and Germany protect this right by providing comprehensive sex education in their schools and implementing public programs to promote sexual health. Abstinence-only education in the United States denies American youth the right to sexual autonomy and prevents them from developing healthy sexual identities. Youth in the United States are far less sexually healthy than youth in these other countries. This paper will examine sex education policies and sexual health agendas in each of these countries and look to them for inspiration in proposing a new sex education and public health agenda for the United States.

Sex education in the United States is in desperate need of thoughtful reevaluation. Adolescents in the United States fare consistently worse on most sexual health measures than teens in other industrialized countries. Comprehensive sex education programs in the Netherlands, France, and Germany support the sexual health of youth. Teens in the US have higher rates of pregnancy and abortion than any European country (Lottes, 2002). Young women in the United States experience intercourse at a younger age, use less effective contraception, and report higher rates of using no contraception at all than young women in every other industrialized country (Lottes, 2002). Nearly sixty percent of US teenage pregnancies are unplanned or unwanted, a very high rate compared to other countries, and rates of curable STDs are higher in the US than any other industrialized country and even some developing countries (Lottes, 2002). Teens in the United States have also been shown to have higher numbers of sexual partners than those in the Netherlands, France and Germany (Labauve & Mabray, 2002). Some factors that put US youth at risk include restrictive ideas about teenage sexuality, lack of openness and discussion about contraception and sexual responsibility, high levels of poverty and uneven distribution of wealth, high levels of religiosity, low availability of contraceptive education and family planning services, and high costs of such services (Lottes, 2002). While all of these factors certainly play a role in the sexual health of teenagers, I have taken a special interest in sex education.

There are no federal laws in the United States requiring that sex education be taught in schools (Weaver, Smith, & Kippax, 2005), but the government allocates funding for abstinence-only sex education that schools may choose to accept. Despite the fact that most parents of school age children support a comprehensive approach to

sexuality education in schools (Berne & Huberman, 1999), abstinence-only education has been the predominant means of sex education since the passing of the Adolescent Family Life Act of 1981. The act encourages abstinence-only education to be taught in schools to reduce teen pregnancy and STD rates (Weaver et al., 2005). In 1996, Congress passed Title V, providing \$50 million a year to fund abstinence-only programs in schools. Funding for these programs has since increased to \$300 million a year (Weaver et al., 2005). Schools receiving funding under Title V must adhere to strict guidelines, including teaching that abstinence is the only way to avoid sexually transmitted infections, pregnancy, and psychological harm, and that childbirth outside of marriage is against social standards and harmful to individuals, parents and society (Labauve & Mabray, 2002). Title V funded programs are only allowed to address methods of contraception, such as condoms or the birth control pill, when emphasizing failure rates and ineffectiveness (Labauve & Mabray, 2002). A study done in the 1990s showed that only 69% of US school districts had a policy in place to provide sex education, while the other 31% left it up to individual schools or teachers to determine sex education policies. Of the school districts with sex education policies in place, 14% were comprehensive, 51% were abstinence-plus (programs which include information about safe sex and contraception while still emphasizing abstinence as the best and most desired method), and 35% were abstinence only (Labauve & Mabray, 2002). It is important to note that while abstinence-based sex education is the norm, programs vary widely between individual schools, districts, and states.

Abstinence-only programs are simply impractical. In the 21st century, age at puberty has decreased and age at marriage has increased, creating a greater gap than ever before between sexual maturity and marriage (Weaver et al., 2005). In Western

countries, sex before marriage has become the norm, and it is statistically less normal for a woman to be a virgin at marriage than a non-virgin (Weaver et al., 2005). In the US specifically, teens begin having sex at an average of 16.3 years of age (Weaver et al., 2005). Abstinence-only sex education ignores these realities. Furthermore, abstinence-only sex education programs have never been shown to be effective in altering teen sexuality activity (Labauve & Mabray, 2002). Abstinence only programs do not prevent teens from having sex, but they do deny them accurate information on STD prevention and contraception, therefore denying them the ability to make informed, responsible decisions about sex.

Sex education programs are also most effective when supplemented with public health programs that provide easily accessible sexual health services to youth, which the US does not have. Unlike teens in other countries, teens in the US face many barriers to attaining sexual health services. There is no universal healthcare system in the US and only approximately 85% of US residents have health insurance (Berne & Huberman, 1999). While condoms are sometimes provided free of charge by health centers and family planning clinics, only 33% of private health insurance plans cover oral contraceptives (Berne & Huberman, 1999). Teens seeking sexual health services rely mainly on private organizations or school-based services, but private organizations tend to target older teens and young adults, and only 22% of school-based health services provide access to condoms or contraception (Berne & Huberman, 1999). Abortion is legal in the United States during the first trimester, but high costs, lack of information, and parental consent requirements discourage teens who seek abortions (Berne & Huberman, 1999).

The US is clearly not providing its youth with necessary measures to achieve sexual health, and should look to other industrialized countries for insight on how to improve. All of the countries under examination in this paper outperform the United States on measures of teenage sexual health. I will start by examining the Netherlands because they have the highest sexual health ratings of any industrialized country. The Netherlands have the lowest rate of unplanned pregnancy, abortion, and teen pregnancy in the western world (Lottes, 2002). The birth rate for teens ages 15-19 in the Netherlands is only 8.2 per 1000, compared to 54.4 per 1000 in the US (Singh & Darroch, 1999). Abortion rate for teens 15-19 in the Netherlands is only 4.2 per 1000, compared to 29.2 per 1000 in the US (Singh & Darroch, 1999). Rate of contraception used at first intercourse is 85% in the Netherlands but only 65-75% in the US (Weaver et al., 2005). Teens in the Netherlands also have fewer sex partners and postpone sexual intercourse longer than teens in the US (Lottes, 2002).

Sex education was officially made mandatory for all Dutch students in 1993 (Weaver et al., 2005). Schools in the Netherlands are required to provide education about pregnancy, sexually transmitted infections, sexual orientation and homophobia, sexual values, respect for different attitudes regarding sex and sexuality, and skills for developing a healthy sexuality (Weaver et al., 2005). Teachers' pre-service education includes training on sex education topics, and additional funding for sex education training is provided by the Netherlands Institute for Health Promotion and Disease Prevention (Weaver et al., 2005). Dutch sex education emphasizes the importance of open discussions about sexuality in the classroom. Discussions are often led by student questions and teachers are allowed to cover any topic in which students express interest (Lottes, 2002). The major themes of Dutch sex education are:

1. **Physical and emotional sexual development:** This topic includes information about puberty of each sex for both sexes and covers physical and emotional changes that occur during puberty. Students are reassured that while they may have worries or concerns about their bodies, these concerns are a natural part of growing up and everything will be ok.
2. **Reproduction:** This topic includes simple, accurate language and illustrations explaining sexual intercourse and reproduction.
3. **Weerbaarheid:** Translated as ‘interactional competence’, this topic addresses assertiveness, communication techniques, personal values, asking for help, and decision making. Weerbaarheid encourages students to think about what they are comfortable with sexually and develop skills to maintain boundaries.
4. **Relationships:** This topic covers heterosexual and homosexual relationships and is often used to transition from discussions of puberty to discussions of sexuality.
5. **Sexuality:** Dutch sex education presents sexuality in a positive light, including information on the positive and pleasurable aspects of sex and relationships. Masturbation is encouraged as a safe, enjoyable way for students to discover their sexual preferences.
6. **Safe sex:** Safe sex is a very important topic in Dutch sex education. The “Double Dutch” method is encouraged- using oral contraceptives to prevent pregnancy and a condom to prevent STIs. The safe sex topic includes information on where to get contraception, how to use it, and what to do if you are nervous about asking for it. (Ferguson, Vanwesenbeeck, & Knijn, 2008)

The ultimate goal of Dutch sex education is to instill a sense of responsibility in youth regarding sexual activity and empower them to make good decisions and set their own sexual boundaries (Ferguson et al., 2008).

The Dutch back up their school based sex education with mass media campaigns and youth-accessible sexual health clinics (Lottes, 2002). Educational sex-related materials concurrent with the concepts taught in schools are provided to parents, clinics, family doctors, and the media (Lottes, 2002). Sexual health clinics follow specific guidelines to assure that they are accessible to youth. These guidelines require that clinics accept teen sexuality and sexual behavior, guarantee anonymity, waive Pap smear and pelvic exams for initial contraceptives, provide nonjudgmental service, and require minimal paperwork and no parental consent (Lottes, 2002).

Next, I will examine sex education and sexual health policies in France. Youth in France fare well on most measures of sexual health. The teen birth rate in France is 22 per 1000 and the teen abortion rate is 13.2 per 1000 (Weaver et al., 2005). The French gonorrhea rate is 74 times less than that of the US and the chlamydia rate is 20 times less (Weaver et al., 2005). Twice as many women in the US begin having sexual intercourse before age 15 as in France (14% and 7%, respectively) (Darroch et al., 2001). French women also have fewer sexual partners than American women, with only 13% of women ages 18-19 having more than two sexual partners in the past year compared to 49% of their US counterparts (Darroch et al., 2001). Only 12% of French women reported neglecting birth control at their most recent intercourse; 20% of US women did (Darroch et al., 2001).

All French schools are required to provide sex education. In 1996, the federal government mandated that students ages 12-14 spend at least two hours in sex education classes and all students over age 13 must attend a mandatory 20 to 40 hours of sex education workshops over a four year period (Weaver et al., 2005). French sex education often starts with questions raised by students and is led by student interest. Curricula focus on biological sexual maturation, reproduction, STD prevention, and contraception (Weaver et al., 2005). Biology teachers cover the biological aspects of development, including reproductive anatomy, and often invite community specialists to speak to students on more expansive topics (Berne & Huberman, 1999). Schools, the media, and community organizations all work together to encourage and enable healthy sexual behavior among youth (Berne & Huberman, 1999).

France supplements its sex education programs with public policies that provide teens with access to condoms and contraception. National health insurance in France

covers all reproductive health services and condoms are provided free and confidentially to anyone under age 18 (Berne & Huberman, 1999). Abortion is free and legal through the tenth week of pregnancy (Berne & Huberman, 1999). One unique aspect of French sexual health policy is “Free Wednesdays”. All students have Wednesday afternoons off from classes, and family planning clinics cater to teens during these times (Berne & Huberman, 1999).

The final country I will examine is Germany. Germany has a teen abortion rate of only 3.6 per 1000 and a teen birth rate of only 12.5 per 1000 (Singh & Darroch, 1999). Germany’s gonorrhea rate is also 25 times less than that of the US (Berne & Huberman, 1999). There is no national curriculum for sex education in Germany. The German government allocates responsibility to schools, community-based organizations, and health authorities to develop appropriate sex education programs, with the requirement that the programs be comprehensive and address a wide range of ages and target groups (Berne & Huberman, 1999). The Federal Center for Health Education is specifically responsible for developing sex education concepts geared toward individual age and social groups and providing uniform educational materials to school, vocational training counselors, and counseling centers (Berne & Huberman, 1999).

German sex education is approached in a positive, non-repressive context and led by dialogue that gradually introduces sexuality to students and presents sex as a positive expression of emotion or tenderness in a relationship (Berne & Huberman, 1999). German sex education strives to provide students with information about physical aspects of sexuality, an understanding of individual sexual development, personal identity, gender roles, and relationships, information on how to develop a healthy sexual life, educational information on pregnancy and prenatal life, awareness of other

lifestyles, and a comprehensive understanding of sexually transmitted diseases and how to reduce risk. German sex education is designed to motivate students to use protection from pregnancy and STDs, make conscious responsible decisions about sexuality and relationships, and accept and tolerate different lifestyles. German sex education helps students become competent in communication regarding relationships, family planning, and STD protection and teaches students to take an active role in intimacy and sexual encounters (Berne & Huberman, 1999).

German sexual health is not only a result of their sex education, but of public policies that support the sexual health of all citizens. Ninety percent of German households have compulsory health insurance, while 10% of households with the highest incomes have access to private insurance (Berne & Huberman, 1999). Oral contraceptives, IUDs, barrier methods, and sterilization are covered by insurance and offered free to women under age 20. National health insurance also covers abortion, which is legal during the first trimester, but parental consent is required for women under age 18 (Berne & Huberman, 1999). Condoms are easily accessible and can be found in pharmacies, grocery stores, restaurants, clubs, and vending machines in public restrooms (Berne & Huberman, 1999). The German people view sexual expression as a basic need and a normal, healthy part of human development, and their public policies support this view.

Clearly, the US is failing at providing adequate sexual education and health services to our youth. The Netherlands, France and Germany outperform the US dramatically in measures of teen sexual health. Each of these countries offers comprehensive, non-judgmental sex education in their schools and supplementary social programs to provide sexual health services to youth. The US should look to these

countries for inspiration. However, it is important to note that concepts of sexuality vary vastly among cultures. Effective sex education programs must be culturally appropriate (Labauve & Mabray, 2002). Simply adapting the policies of another country would not solve United States' sexual health problems. In fact, due to the incredible cultural variations between states and regions in the United States, I would suggest that the implementation of a single, national sex education curriculum would also be ineffective. Comprehensive sex education, starting in elementary school and continuing throughout high school, should be mandatory in schools across the country, but it should be up to individual states to develop a curriculum that meets the specific needs of its population.

Comprehensive sex education programs in the US should be based in theory and research and target at-risk populations. As stated by Schaalma et al. (2004): "Health promotion planners need to identify theory- and evidence-based methods that have proven, or are likely to, be effective in changing behavior, and they need to translate these methods into educational strategies and materials that fit target populations" (Schaalma, Abraham, Gilmore, & Kook, 2004, p. 261). Health promotion planners should look to the countries reviewed earlier in this paper for examples of methods that have proven to be effective and translate them to meet the needs of different US populations. All teachers should be trained in sex education while pursuing their teaching degrees. Teachers who already have their degrees and are currently teaching should be required to attend sex education seminars to provide them with skills for addressing sex education topics in the classroom.

While each state should be free to establish a program that most meets the needs of its population, there should be some principles common to all programs. First, the programs should provide comprehensive information about sexuality, relationships,

sexual identities and diversity, setting boundaries and respecting the boundaries of others, developing effective communication skills, preventing STDs, successfully using contraception. Sex should be regarded in a positive way; programs should not induce fear or deny the pleasurable aspects of sex. Sexual development should be viewed as a normal part of growing up, and sex within relationships should be presented as an ideal, without condoning (condoning implies allowing something to go on that's morally suspect) other sexual relationships. Students should be encouraged to explore their own sexuality through masturbation before engaging in sex with a partner.

For sex education programs to be effective they must do more than just provide information. Effective sex education programs must influence psychological processes of decision-making and pursuing goals. These programs should be informed by cognitive theories that have been used successfully to address other health behaviors, like drug abuse prevention programs (Schaalma et al., 2004). Sex education programs need to provide students with decision-making, communication and negotiation skills and an ability to resist social pressure (Schaalma et al., 2004). One of the most effective means of teaching these concepts is through social rehearsal or role playing activities. These activities provide students with skills to deal with many situations and are especially useful to students who don't yet have actual experience with these situations (Schaalma et al., 2004). Because sexuality is a sensitive topic for many students, a safe classroom atmosphere must be maintained. Students must be comfortable participating in activities and asking questions in order to truly benefit from sex education courses. A safe atmosphere can be established by setting confidentiality rules and engaging the class in "feelings-and-values" exercises before introducing the sex education topics. "Feelings-and-values" exercises encourage students to discuss feelings of

embarrassment and what they mean, as well as set limits about what information is appropriate to disclose in a classroom (Schaalma et al., 2004).

Media literacy, defined as the ability to access, analyze, evaluate, and communicate messages in a wide variety of forms (Pendleton et al., 2008), should be an important component of sexuality education in the United States, where adolescents report that they view television as an important source of information on birth control, contraception, how to talk to a boyfriend or girlfriend about sexual issues, and norms for sexual behavior (Eye, Kunkel, Bialy, & Finery, 2007). Media literacy has proven to be an effective component of sex education in the past and research has shown that individuals who understand media production recognize that messages in the media are carefully constructed and are better able to identify motives, purposes, and points in the media they are exposed to (Pendleton et al., 2008). Images of sexuality dominate media in the United States and students need to be equipped with skills to analyze and deconstruct the messages they receive.

The United States should also initiate social health programs that support the values being taught in sex education and allow teens access to sexual health services. All citizens of the United States should have access to health insurance that covers sexual and reproductive health needs. Condoms should be cheap and easily accessible; putting vending machines in school restrooms and other public restrooms would be a good way to spare teens any embarrassment about buying them at a pharmacy. Sexual health clinics should be established in locations that are easily accessible to youth and be open during after-school hours and on weekends. These clinics should follow the same guidelines as those in the Netherlands. Abortion should be free and legal and minors should not be required to have parental consent. Pre- and post- procedure counseling

should be supportive and nonjudgmental. Finally, national mass media campaigns should encourage safe sex and responsible decision making and make youth aware of the resources available to them in their community.

Of course, there are obstacles to achieving these goals. Sex education is a largely moral issue in the United States and many religious groups fight adamantly against anything but abstinence-only programs. Many adults have misconceptions about comprehensive sex education, believing it will cause youth to become sexually promiscuous, which has been found untrue (Labauve & Mabray, 2002). The foreign countries presented in this paper have much more open, matter-of-fact attitudes about sexuality, as opposed to the more subjective views prevalent in the US. The US will need to adopt a fact and research based approach to human sexuality before any of the programs I suggest can be initiated at a national level. Discouragingly, even if the US adopts a comprehensive sex education curriculum and funds sexual health services for youth, the entire problem will not be solved. Other major causes of poor sexual health in the US are the high poverty rates and uneven distribution of wealth (Lottes, 2002). As long as high numbers of American youth are living in poverty, US teen sexual health will continue to rate worse than that of other industrialized countries.

While the US situation appears grim right now, there is hope. Citizens should encourage national and local governments to fund sexual health services for youth and push for a national health insurance system that covers all citizens. When these goals are accomplished, we should begin to see a much more sexually responsible youth.

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