European Approaches to Adolescent Sexual Behavior & Responsibility

Executive Summary and Call to Action

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Advocates for Youth—Helping young people make safe and responsible decisions about sex

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Advocates for Youth is dedicated to creating programs and promoting policies which help young people make informed and responsible decisions about their sexual and reproductive health. We provide information, training, and advocacy to youth-serving organizations, policy makers, and the media in the U.S. and internationally.

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Foreword:

A New Vision for Adolescent Sexual Health

Rights. Responsibility. Respect. This trilogy of values underpins a social philosophy of adolescent sexual and reproductive health in the Netherlands, Germany, and France—the countries visited by a 1998 study tour, composed of 42 U.S. experts and graduate students in adolescent sexual health.

In these countries, government and society view accurate information and confidential services, not merely as needs, but as rights of adolescents. These rights, in turn, depend upon societal openness and acceptance of adolescent sexuality. In short, the Dutch, the Germans, and the French expend less time and effort trying to *prevent* young people from having sex and more time and effort in *educating* and *empowering* young people to behave responsibly when they decide to have sex. Each of these nations appears to have an unwritten social contract which states, "We'll respect your rights to independence and privacy; in return, you'll take the steps you need to take to avoid pregnancy, HIV/AIDS, and other sexually transmitted diseases."

Is this a formula for lax morality and promiscuity? The young people in the countries we visited commence sexual intercourse a year or two *later* than do U.S. teenagers. Further, the Netherlands, Germany, and France boast better public health outcomes—the teenage birth rate in the Netherlands, for example, is nearly eight times *less* than in the United States. Germany's gonorrhea rate is nearly 25 times less than the U.S. rate.

So, if Dutch, German, and French teens have better health outcomes *and* delay the onset of sexual activity longer than do U.S. youth, what's the secret? Do we have a 'silver bullet' solution for the United States that will reduce its three million new STD infections among teens each year, or the 6,000 cases of HIV infection reported so far among those ages 13 to 24, or the 800,000 teen pregnancies each year?

Could the 'silver bullet' solution for the United States be a mass media campaign like those in Europe that boast a single, consistent message—*safe sex or no sex*? Is it a public health system that makes contraception available at little or no expense? Could it be the fact that public health policy is based on public health research, rather than relying on the political or "moral" agendas of a strident minority?

Unfortunately, there is no single, 'silver bullet' solution. The mass media campaigns, the public health systems, and public health policies have their part in the Dutch, German, and French successes. Yet, success doesn't really rest on programs and services alone. It is the societal thinking—the norms—that make the Dutch, German, and French successes possible. It is the openness and the acceptance that young people will have intimate sexual relationships without being married and that these relationships are natural and contribute to maturing into a sexually healthy adult. It is the refusal to brand the expression of sexuality as deviant behavior or to cast it solely in a negative light. It is the determination to present sexual expression as a balance—a normal part of growing up *and* a responsibility to protect oneself and others. It is the respect these societies have for adolescents, valuing them as much for who they are as for the adults they will become.

But how relevant is all of this to the United States? The United States is larger, more populous, and more diverse than these European nations, and its cultural values are different. However, size and diversity do not explain the dramatic differences in public health indicators between the United States and the Netherlands, Germany, and France. They do not explain why the United States has a higher teen birth rate than the Netherlands, France, Germany, *and* Morocco, Albania, Brazil, and more than 50 other developing countries. They do not explain the dramatic differences in HIV and STD rates between the United States and the three European nations.

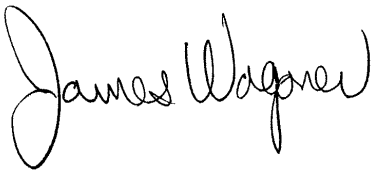
We need to look deeper—not just at contradictory and confused public policies but also at the contradictory norms that underlie those policies. As a society, we are uncomfortable discussing sexuality issues and, especially, teenage sexuality. Advertising and programming in the entertainment media too often send sexual messages that seem to say, "Just do it!" The recent, Congressionally-mandated message to students is "Just say no, until you're married." As a result, methods of dealing with teenage sexuality include pretending teens do not have sex or attempting to control and limit information about sex and contraception.

The negative message to teens is clear—"You shouldn't have sex, so protection is irrelevant!" No wonder many young people in the United States are not motivated to be sexually responsible; and when they are, they are too often thwarted as they seek the information and services they need.

Despite U.S. adults' general discomfort with the subject of teen sexuality, the vast majority do not agree with "head in the sand" approaches. Instead, the majority of adults say they want young people to have the information and services they need. The challenge will be to build on these positive attitudes and to articulate the values of honesty, openness, respect, and responsibility that promise to underpin a new, successful approach to adolescent sexual health in the United States.

Although the European experience can be helpful in guiding this effort, the United States cannot simply adapt European approaches completely. We are different in many ways. We place a greater value on abstinence and—given the early age at which our teens commence sexual activity—that is a good thing. But valuing abstinence must *not* override young people's rights to accurate information that can protect and even save their lives. At a time when 70 percent of 18-year-olds in the United States have had sexual intercourse, we cannot afford to ignore the needs of sexually active youth.

But we can use the experience of the Dutch, the Germans, and the French to help us find a more balanced approach to adolescent sexual health. Indeed, the three 'Rs' of sexual health—rights, responsibility, and respect—may help us overcome obstacles and achieve social and cultural consensus on sexuality as a normal and natural part of being a teen, of being human, of being alive.



James Wagoner,
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European Approaches to Adolescent Sexual Behavior and Responsibility

Executive Summary

Teen birth, abortion, and sexually transmitted disease (STD) rates in the United States are higher than in most other industrialized countries. For the last two decades, U.S. public health experts have worked to address these problems. One such effort, sponsored by Advocates for Youth and the University of North Carolina at Charlotte, is the Summer Institute, a six-credit graduate course about adolescent sexuality. In 1998, the Institute initiated an international fact-finding mission to the Netherlands, Germany, and France to explore how these European nations have achieved successful adolescent sexual health indicators. A team of 40 adolescent health experts and graduate students from throughout the United States, along with two teen journalists, participated in the mission.

In each country, the participants conducted qualitative, critical analyses of issues which research demonstrates to have an impact on adolescent reproductive and sexual health attitudes, behaviors, and outcomes. Those issues, and the public policies and practices related to them, include:

- Access to health care, especially reproductive and sexual health services,
- Sexuality education,
- Mass media and social marketing campaigns, and
- Family, community, and religion.

Comparing the four countries, U.S. teens are the youngest—at an average age of 15.8— to experience first sexual intercourse.[1] Teens in the Netherlands—which exhibits the most liberal attitudes about sexuality and sexual behavior—experience first intercourse at the latest average age, 17.7.[2] The teens of Germany and France experience first sex at 16.2 and 16.8, respectively.[1, 2]

Teen condom use is fairly consistent among the four nations. In the Netherlands, 85 percent of Dutch adolescents use protection at first sexual intercourse—46 percent use condoms and 24 percent use both condoms and the pill.[2] Further, 29 percent of sexually active teens used condoms at most recent intercourse, while eight percent used **both** condoms and oral contraceptives at the same time.[3] In Germany, 56 percent of sexually active male teens used condoms at first intercourse and 57 percent at most recent intercourse.[4] In the United States, teens' use of condoms or other contraception at first intercourse has risen to 65 percent.[5] Among sexually active U.S. teens, 65 percent reported using

a condom at most recent intercourse.[6, 7] Finally, in a nationally representative sample of sexually experienced U.S. youth ages 14-22, 25 percent of young men reported dual use of condoms and oral contraception.[8]

Differences emerge strongly when teen use of other effective means of contraception is compared. In the Netherlands, nearly 67 percent of sexually active adolescent females use oral contraceptives.[9] In Germany, about 63 percent of sexually active adolescent females report using oral contraceptives at most recent intercourse.[4] By contrast, 20.5 percent of sexually active adolescent females in the United States report using oral contraceptives at most recent intercourse.[7]

The United States has much higher rates of teen birth and abortion when compared with the other three nations. In 1996, the U.S. adolescent fertility rate was 54.4 per 1000 women ages 15 to 19, four times higher than Germany's rate of 13 per 1000.[10,11,12] The Netherlands has the lowest confirmed teen fertility rate in the world—6.9 per 1000 women ages 15 to 19.[3] While teen abortion rates are not available for Germany, the abortion rate for U.S. teenagers is more than double that of France and more than triple that of the Netherlands.[3,11,13,14]

The United States also has the highest poverty level among major industrialized nations. In measuring poverty in industrial economies, United Nations analysts look at longevity, literacy, disposable income below 50 percent of the median, and long-term employment. With those measures, the United States earned a poverty score of 16.5 percent; by comparison, the Netherlands scored 8.2 percent, Germany scored 10.5 percent, and France scored 11.8 percent.[14a] Poverty is significant to adolescent sexual health indicators because of its association with adolescent pregnancy and its impact on youth goals, aspirations, and risk behaviors.[14b]

Media

Young people in the United States receive mixed messages regarding sexuality. Entertainment media frequently portray young, single people engaging in casual sex with no contraception, no consequences, and often no feelings for each other. Media frequently portray uncommitted, casual sex as desirable; characters rarely suffer ill effects from "one night stands." A television prime time analysis reveals that the average adolescent in the United States views 14,000 sexual references, jokes, and innuendos each year.[15] However, only one in 85 of these references will mention abstinence, contraception, or marriage, sometimes negatively.[16]

The SHINE Awards (Sexual Health in Entertainment)—sponsored by Advocates for Youth and the Henry J. Kaiser Family Foundation—annually recognize entertainment industry efforts to provide responsible sexual health messages. In 1982, the National Association of Broadcasters lifted a ban on contraceptive advertising, and polls show that Americans favor contraceptive advertising and portrayals of responsible sexual behavior in the media.[16a] Yet, most major networks air no commercials or public information campaigns about sexual health.

In 1996, the United States Congress approved America's first national campaign to prevent teen pregnancy, as a part of the Welfare Reform Act, and funded a national "Abstinence Until Marriage" campaign with $250 million to distribute to the states over five years. Many states are using the money for media campaigns targeting teenagers with messages to wait until they are married to have sex. Tour participants encountered no sexuality education or public health experts in the Netherlands, Germany, or France who thought this approach would be effective. Some of the European professionals worried that this strategy—by depriving U.S. teens of necessary information about condoms, contraception, and safer sex behaviors—could drive U.S. teen rates of birth, STD, and HIV higher.

The United States has provided its people with few continuous, long-term national media prevention campaigns about risky sexual behavior. While effective posters, videos, and print materials have been developed for specific groups, these materials have not been widely or consistently distributed except in urban, largely gay areas. Some safer sex media efforts, quietly implemented and targeting gay males and injection drug users, have been effective. Unfortunately, the results are not widely publicized and the programs are seldom replicated.

Over the past 12 years, primarily in response to the AIDS pandemic, the government of the Netherlands has invested heavily in mass media and public education campaigns. These efforts have played a positive and direct role in

breaking down societal taboos about discussing protective sexual behavior.[18] Officials in the Netherlands believe that mass media campaigns have distinct advantages over other strategies in that they

- Keep sexual health on the public agenda;
- Reduce stigma by emphasizing community responsibility for health problems;
- Serve in educating youth by providing catalysts for discussion and by reinforcing messages;
- Reach higher risk groups not generally accessible through traditional channels;
- Encourage intermediaries (teachers, youth workers, pharmacists) to draw attention to safer sex; and
- Stimulate organizations to provide training and education to intermediaries.[19]

The Netherlands' mass media campaigns do not operate in isolation, and the development of strategies for impacting sexual health in the Netherlands is quite different from efforts in the United States. First of all, the Dutch government takes a "hands off" approach. In regular cycles, the government provides public funds to the organizations charged with altering sexual health behaviors. The government attaches no strings or restrictions on content or explicitness, instead trusting the agencies to develop effective strategies based on research. Continuing evaluation helps the experts keep abreast of trends in the population's knowledge, attitudes, beliefs, skills, behaviors, and sexual health outcomes. Using this information, agencies develop and implement appropriate campaigns.

In 1988, agencies introduced the first summer holiday campaign. Prior research indicated that 40 percent of Dutch youth ages 15 to 20 had romances while on vacation and that 30 percent of the romances included unprotected sexual intercourse. To increase safer sex during holiday romances, agencies developed packets which contained information, condoms, and brochures in several languages to help Dutch youth negotiate safer sex with potential partners. The campaign's success was measured by increased condom use among Dutch youth.[19]

The campaigns of 1989-1991 focused on excuses for not using condoms, and the 1992-1994 campaigns worked to achieve changes in social norms, using social learning theory, and the theme, "I'll have safe sex or no sex." The 1995 campaign related to communication skills: "I'll take something off if you put something on." The 1996-1997 campaigns focused on STDs, including HIV/AIDS, with the "STD Top 10" and another communication clip, "Your condom or mine?" The 1998 campaign produced a popular and humorous commercial, the "Too Early—

Too Late" campaign, featuring people of all ages and in all walks of life bringing up the topic of condoms either too early, too late, or at just the right time.

While recent campaigns have focused heavily on the prevention of STDs, including HIV, the Dutch have long supported efforts to prevent unintended pregnancies. Seeing abortion as a social failure, the Netherlands has effectively promoted oral contraceptive use since the early 1980s to prevent unintended pregnancy and reduce the need for abortion. To prevent both STDs and unintended pregnancy, strategists developed the "Double Dutch" message, encouraging sexually active people to employ two methods of protection—the pill and the condom.

Dutch efforts have not attempted to deter young people from sexual relationships. Instead, the Dutch focus has been on the positive aspects of a sexual relationship and on sexual responsibility to prevent unintended pregnancies and STDs, including HIV.

In 1997, a government sponsored evaluation determined that safer sex campaigns were effective. Among 1500 Dutch citizens ages 15 to 45, evaluators found:

- From 1987 to 1997, the percentage of persons who used condoms with a casual partner increased from 9 to 58 percent; only 16 percent never used condoms.
- From 1991 to 1997, the percentage who agreed that STDs were a reason to use condoms grew from 67 to 85 percent.
- From 1987 to 1997, the percentage who know that condoms protect against STDs increased from 74 to 96 percent.
- From 1992 to 1997, those who found it difficult to discuss condoms with a new partner decreased from 18 to seven percent.[2]

The Germans have been aggressive in developing and distributing safer sex messages. Under the authority of the Ministry for Health, the Federal Center for Health Education (FCHE) has produced nationwide media campaigns that rely on integrated public and private efforts. Four to six television spots are produced annually and aired through cooperative agreements with television stations which have donated some five million dollars (U.S.) worth of free air time.[20] Outdoor billboard and poster campaigns present new educational themes at three-month intervals, and printing and advertising partners provide free printing as well as distribution in some 70,000 locations.

German national efforts have focused on preventing the further spread of HIV/AIDS by educating and motivating people to use protection. Knowledge and behavior changes targeted include:

- Recognizing the need for protection
- Knowing protection options
- Developing motivation to protect oneself and others
- Building communication skills
- Learning safe and unsafe behaviors with people infected with HIV
- Changing beliefs about HIV-infected people.[21]

FCHE developed three elements to decrease public fear and enable HIV-infected persons to reintegrate into society : mass media campaigns, a telephone hotline, and personal communication through intermediaries. The media campaigns feature interpersonal relationships, sexual situations, holiday travel, and leisure time; messages are disseminated through TV and cinema spots, advertisements, and posters. More information is provided through leaflets, brochures, films, and documentaries. The telephone hotline, featured in all media campaigns, provides anonymous, personal counseling by trained staff. FCHE also encourages personal communication through campaigns which extend the mass media messages to the grassroots level through public events, exhibitions, health fairs, and mobile vans.

This integrated, national, multimedia campaign has incorporated process and impact evaluation. In a recent 10-year evaluation, computer-aided telephone interviews of approximately 3600 randomly selected German residents found that:

- Among individuals who had multiple partners, condom use increased from 21 percent in 1988 to 57 percent in 1995.
- Of those who had sex with unfamiliar partners, the percentage who always used a condom doubled from 23 percent in 1989 to 45 percent in 1995.
- Of those who were single and ages 16 to 45, condom use rose from 58 percent in 1988 to 69 percent in 1995.
- In 1984, only 25 percent of respondents had ever used a condom. By 1995, 83 percent had used a condom.[22]

France's mass media efforts have been less strategic than the Dutch or German campaigns, but they have been more extensive than those of the United States. The Ministry of Health, in public-private partnerships, established its first policies for campaigns in 1986 and produced campaigns through the Regional Center for the Prevention of AIDS (CRIPS) and the Association for AIDS. Because France is predominantly Catholic, efforts have focused entirely on disease prevention, particularly HIV/AIDS rather than on pregnancy prevention. More recent efforts also focus on preventing STDs.

In 1987, French public health officials and the government promoted condom use through national media with the intent to normalize the use of condoms in sexual relationships.[23] The French programs also encourage simultaneous dual methods and use posters, billboards, TV and radio commercials, special events, hotlines, pop and disco music, special products, and competitions to get their messages out.[24]

CRIPS consistently uses a powerful marketing tool—involving the target group—in producing safer sex materials. More than any of the other countries studied, France encourages adolescents to produce the messages targeted to teens. For example, CRIPS sponsored a nationwide poster contest among school students to create ideas for AIDS prevention campaigns. Teens submitted over 5,000 posters, and professional graphic designers worked with the young artists to produce the finished products for national distribution. The poster campaigns also stimulated ideas for commercials, advertisements and instructional aids.[25] Most French media campaigns are creative, explicit, and humorous. A few contain partial nudity. The campaigns depict couples that include same sex, racially mixed, young, and old. Heterosexuality and homosexuality are depicted openly and honestly.

Reproductive and Sexual Health Services for Teens

The health care system in the United States is cumbersome and complex and varies from state to state. Approximately 85 percent of U.S. residents have health care coverage through either public or private health insurance. About 15 percent of the population—some 37 million people—have no form of health care coverage. These people tend to be ages 18 to 24, nonwhite, or unemployed.[26] Young, unemployed, and uninsured people who lack financial resources may also have reduced access to effective contraception.

Reproductive health care is among the services least likely to be covered in the U.S. health care system, particularly for teens. Although no U.S. health care policy is known to pay for condoms, many health maintenance organizations (HMOs), family planning clinics, and school-based health centers provide free condoms. While 97 percent of employer plans cover prescription drugs, only 51 percent pay for prescription contraceptive methods, and only 15 percent pay for all five of the most common, effective, and reversible forms of contraception—IUD, diaphragm, Depo Provera, Norplant and oral contraceptives. Only about 33 percent pay for oral contraceptives, the most widely used form of female contraception other than sterilization.[27]

Teens have access to reproductive health services through private organizations and school-based services. Planned Parenthood Federation of America provides education and reproductive health services but targets older teens and young adult women for services. School-based health centers, partly funded through Maternal and Child Health Bureau grants as well as by private foundations, provide health services for more than half a million teens in the United States; however, only 26 percent of the school-based health centers that serve teens provide access to condoms or contraception.[28]

Abortion is legal in the United States, and women may choose the outcome of their pregnancies during the first trimester. States regulate second trimester abortions and impose a variety of laws to reduce the demand for abortion, including mandatory waiting periods and parental consent requirements.

Emergency contraception—'morning after' contraception—has been legal for over 20 years, but has been relatively unknown and unused by women in the United States. Slightly more than 28 percent of U.S. teenagers have heard of emergency contraception.[29] Many teens in the U.S. are unaware of and fail to seek appropriate reproductive health services in a timely manner, and a pregnancy or STD often drives U.S. teens to seek reproductive health services.

In 1969, the Netherlands legalized selling contraceptives and providing condoms in vending machines. By 1971, national health insurance included coverage for the pill. In 1981, the Netherlands legalized abortion although high levels of contraceptive use had already begun to drive abortion rates lower than in surrounding countries. In the early 1980s, the Dutch government funded the Rutgers Foundation to provide special services for adolescents, reproductive health care to the public, and sexuality education. The Rutgers Foundation currently runs seven sexual and reproductive health centers [30] and employs a multidisciplinary staff of doctors, nurses and psychologists who provide contraception and emergency contraception, test for pregnancy and STDs, diagnose fertility problems, and provide sexual abuse counseling.

Because the Netherlands has many port cities, controlling STDs has been a major health concern. Easily accessible STD clinics, fully funded by the government, provide testing, treatment, and education. Walk-in clinics are strategically located and easily accessible for target populations. Clinics provide early STD diagnosis, rapid STD treatment, and free HIV testing. Clinics also offer free pre- and post-test counseling, contact tracing, and treatment of infected partners as well as examinations and counseling for sexual assault. Finally, clinics provide safer sex outreach and education. Treatment is offered to everyone at no cost.[31]

National Public Health Insurance funds all reproductive health services—contraceptive pills and devices, emergency contraception, abortion, testing for pregnancy and HIV/ STD, prenatal care, delivery, and all drug therapy associated with the early diagnosis and treatment of STD, HIV, and AIDS. Only condoms are not funded. Over 99 percent of the Dutch population have full health coverage.[32] Dutch teens have excellent access to the best methods of protecting themselves. Sexually active teens encounter nonjudgmental attitudes and strong adult convictions that young people must be sexually responsible. Services are confidential and free or low cost. While the Netherlands has a minimum age of consent, it is waived when a doctor or clinician believes waiver to be in the young person's best interest.

The German government regulates insurance, and 90 percent of households have compulsory health insurance. Private insurance is available for the remaining ten percent of households with very high incomes. Even though patients must meet co-payment fees, these fees remain substantially lower than those in the United States. In addition to subsidizing health care for almost all of its residents, the German government provides generous support for sexuality education, family planning, and contraceptive services.[33] Most Germans believe that sexual expression is a basic need and a normal, healthy part of personality development. Germans believe that sexuality is to be handled responsibly. German residents enjoy access to condoms and contraception with few barriers.

Oral contraceptive pills, IUDs, barrier methods, and sterilization are covered by insurance and are free of charge to women ages 20 and under.[34] Adolescents need not visit a physician to get contraception.[23] Germans view contraceptive use as indispensable to sexual intercourse,[34] and many German adolescents effectively use contraceptive methods. Some 63 percent of German teens use oral contraceptives and 57 percent use condoms.[4] Condoms are widely available in pharmacies, grocery stores, restaurants, clubs, and in vending machines in most public rest rooms. In general, Germans view contraceptive use as the way to avoid abortion.[35] Parents, schools, and communities support teens' use of protection when they become sexually active.

In 1996, Germany legalized abortion within the first trimester and with "proper counseling" which emphasizes the life of the fetus but leaves the final decision to the woman. Second trimester abortion is not permitted unless pregnancy endangers the mother's life. Abortion is also covered by the national health plan and counseling is required three days prior to the procedure.[36] German law requires parental consent for abortions in women under age 18, but doctors may perform abortions for women as young as 14 who fully understand the ramifications of the procedure.[35]

The French health care system faces rising costs; yet, the country remains committed to national health insurance coverage.[37,38] About 99 percent of French residents are covered by health insurance.[39] National health insurance covers all reproductive health services. In 1967, the French government revoked a 1920 law restricting access to contraception. In 1974, Parliament permitted family planning clinics to dispense condoms and contraceptives and required that services be confidential and free to those ages 18 and under.[39] The age of consent is 15.

The main reason for providing low cost to no cost protection is to reduce the demand for abortion. Abortion is legal and free through the tenth week of gestation, but women seeking abortion must wait 10 days. Second trimester abortions are legal only when the pregnancy endangers the life of the mother, as determined by two consulting physicians. Approximately 18 percent of abortions are accomplished through administration of RU-486 (mifepristone), which is legal until the fifth week of gestation. Minors seeking an abortion must have the consent of at least one parent although doctors ignore this requirement when they think it is in the best interest of the young woman.[39]

The French use innovative strategies to make contraception more accessible for adolescents. One successful approach is Mercredi Libre, or "Free Wednesday." Students in French schools have Wednesday afternoons off, and family planning clinics cater to teens on those days. Clinics permit walk-in appointments and also set up educational programs to entice teens to visit, alone, in couples, or in groups. The French increase access to contraception through condom vending machines, located throughout the country in places frequented by teens.

France has many STD and family planning clinics which provide education, counseling, condoms and contraception, STD testing, and gynecological exams. Overall, teens seeking reproductive health services encounter few barriers in France. Services are free, conveniently timed, and promoted by adults. Condoms are cheap, contraception is free, and both are widely available. Abortions are free and legal, though not condoned. The focus, in this predominantly Catholic country, is on preventing abortion through responsible sexual behavior.

Sexuality Education

In the United States, education is controlled by the individual states which may leave decisions to the local level or may set guidelines for curricula and subject matter. Twenty-two states and the District of Columbia require schools to provide both sexuality and STD/HIV education; another 15 states require STD/HIV education; and 13 states have no requirements.[40] Before 1998, 10 states required that sexuality education programs teach abstinence and did not require the inclusion of information about contraception. Thirteen states required that sexuality education teach abstinence in addition to information about condoms and contraception.[41] Most mandates for abstinence education came from state legislatures rather than from state departments of education.

In the United States, instruction about sexuality varies widely because decisions about curricula are usually determined locally; however, some general observations can be made. Most schools concentrate sexuality education in grades seven through nine and confine the unit to the health or science curriculum. Often, instructors have little or no training in sexuality education. The curricula often range from one to 15 classes, and average five classes.[42] Sexuality education is seldom integrated with other aspects of health education, such as drug education, or with other courses such as social studies, literature, and humanities.

In the 1990s, sexuality education in the United States took a behavioral focus with two distinctive and widely separated approaches. The first, *abstinence-until-marriage*, limits instruction to why young people should not have sex until they are married. The second, *balanced and realistic* sexuality education, encourages students to postpone sex until they are older and to practice safer sex when they become sexually active. Studies of sexuality education in the United States show that most frequently taught subjects include factual information about growth and development, reproductive systems, dating and setting limits, abstinence and refusal skills, pregnancy and parenting, and STDs, including HIV.

In 1996, as a part of the Welfare Reform Act, Congress for the first time passed legislation setting national policy for sexuality education and appropriated 250 million dollars over five years to implement abstinence-until-marriage programs. A funded program must adhere strictly to the following:

- Have, as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity.
- Teach school age children abstinence from sexual activity outside marriage as the expected standard of behavior.
- Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, STD, and other associated health problems.

- Teach that sexual activity outside marriage is likely to have harmful psychological and physical effects.
- Teach that bearing children out-of-wedlock may have harmful consequences for the child, the child's parents and society.
- Teach the importance of attaining self-sufficiency before engaging in sexual activity.[42]

Abstinence-until-marriage programs do not acknowledge teen sexual behavior because proponents believe that sex outside of marriage is immoral. Consequently, these programs do not teach young people how to protect themselves when they become sexually active. Contraception and condoms may be mentioned only when discussing failure rates. The consequences of STDs, guilt, and shame are used to frighten youth into abstinence. Despite these limitations, 48 of 50 states have applied for and accepted the abstinence-until-marriage funds.[41]

A union of conservative advocacy groups have joined together to form the National Coalition for Abstinence Education (NCAE). The NCAE monitors expenditures in the states and materials purchased, requests copies of purchase receipts from school districts, charges teachers it perceives to be violating the abstinence-until-marriage mandate, and publishes a report card of its evaluations for each state in regional newspapers. The intensity of the scrutiny by the NCAE and its harassment in some cases have caused some local districts to return the funding or not to apply for funding.[43] Some schools now limit their instruction to abstinence-until-marriage, often omitting lessons on sexual intercourse, condoms, contraception, and protective sexual behavior.

The second U.S. approach, defined by proponents as accurate and balanced sexuality education, takes a broader perspective. Students are encouraged to postpone sex until they are older and then to lower their risk of negative consequences by using safer sex practices. These programs utilize principles of social learning theory and emphasize communication, negotiation, and problem-solving skills. They also provide information and skills development to reduce exposure to STDs, HIV, and pregnancy among sexually active teens. Unlike abstinence-only or abstinence-until-marriage programs, many of the balanced, realistic programs have undergone rigorous evaluation and have been shown to be effective with targeted groups.

The World Health Organization and UNAIDS have each reviewed the research on abstinence-only and balanced, realistic sexuality education programs. The reviews found that no abstinence-only (or abstinence-until-marriage) programs has been proven effective, while some balanced, realistic programs have been effective in delaying first intercourse and in increasing the use of protection by sexually active youth. Additionally, balanced, realistic sexuality education programs have not increased the level of sexual activity, caused earlier sexual activity, or increased the number of sexual partners among sexually active youth.[44,45]

The unfortunate reality is that politics polarizes sexuality education in the United States. While polls consistently indicate that the majority of U.S. parents want their youth to receive accurate sexuality education in the schools, a belligerent minority threatens administrators with community controversy and negative media attention if sexuality education actually deals with sexuality.

The most recent national poll found that 89 percent of public school parents feel that the public high schools should include sex education in their programs:[43] 87 percent of adults think high school students should learn about birth control; 77 percent say students should learn about premarital sex; 70 percent support teaching about abortion; 65 percent support teaching about homosexuality; and 92 percent think youth should learn about HIV and other STDs.[46]

Education is highly valued in the Netherlands. Officials credit parental choice in education with encouraging competition between schools for students, improving the quality of teaching, decreasing levels of bureaucracy in and around schools, and reducing costs.[47] School sexuality education plays a "matter of fact" role in young people's psychosexual development. The Netherlands has no sexuality education curriculum and no single national textbook for student instruction. The content of sexuality education has never been mandated. Until 1993, sexuality education was not an obligatory part of the school curricula. Yet research shows that nine out of 10 Dutch youth receive school sexuality education, regardless of the schools they attend, and approximately half of the primary schools and almost all secondary schools address a wide range of sexuality related issues.[2, 48,48]

The general philosophy of sexuality education in the Netherlands is not to teach but to talk about sex.[3] Dutch teachers approach sexuality issues with their students, no matter what subject they teach, and sexuality education is integrated into many school courses. All teachers have complete freedom to teach anything the students want to learn about sexuality.[2,18,48] Because the Dutch believe students should be active in their own education, students' questions drive the lessons and any topic may be openly discussed, including homosexuality or masturbation. Teachers emphasize communication and negotiation skills but direct little attention to negative consequences of sexual behavior.[48,49]

In Germany, sexuality education must be comprehensive and address the widest range of age and target groups.[21] Germany has no national curriculum or special course on sexuality education.[50] Teachers and principals have the freedom to conduct their programs in any manner they desire.[51] Often, teachers will invite guest lecturers from community-based reproductive health organizations such as ProFamilia.[52]

The German Federal Constitution Court Schools gave responsibility for sexuality education to schools, community-based organizations, and the highest health

authorities.[22] Three tasks assigned to the Federal Center for Health Education include: 1) developing concepts for sexuality education—each geared toward individual age and social groups—for the purpose of promoting preventive health care and avoiding or resolving conflicts in pregnancy; 2) disseminating uniform educational materials throughout the nation; and, 3) distributing free educational materials to schools, vocational training schools, counseling centers, and all other institutions involved with youth and education.[52] This responsibility rests on a belief that sexuality is an integral part of physical and psychological health, and sexuality education is an integral component of health education.

Germany now ascribes to emancipatory sex education, a positive, non-repressive, and dialogue-based approach which gradually introduces sexuality and provides information and support for sex as an expression of emotion and tenderness. Relationships are a primary concern and provide a dual responsibility for sexual behavior. The strategies of this sexuality education are theme-centered interaction, role playing, and exploration, rather than traditional lectures.[51]

Sexuality education should provide:

- Learning about physical processes related to sexuality
- Understanding individual sexual development, finding a personal identity, understanding gender roles, finding a partner, and building relationships
- Shaping a full sexual life and its understanding positive effects
- Learning about pregnancy and prenatal life
- Discovering different lifestyles and creating life plans
- Understanding sexually transmitted diseases, risks, routes of transmission, and protective options

Sexuality education should motivate students to:

- Use options for protection from unwanted pregnancy and STDs
- Acknowledge the responsibility of both partners for contraception
- Consciously shape sexuality, relationships, and partnerships
- Accept and tolerate different lifestyles and life plans

Sexuality education should build competence in:

- Developing communication and action skills in the areas of partnership, family planning, sexuality, contraception, and protection against STDs
- Experiencing sensations and consciously shaping intimacy and tenderness

- Developing the ability to deal with conflicts, particularly for preventing sexual exploitation, sexual abuse, and violence.[53]

Sexuality education is a relatively new subject for French teachers and is not carried out as systematically as many other subjects in France. National policy requires two hours of instruction during each of the lower secondary years; but efforts are under way to lengthen this requirement. Until the AIDS epidemic, sexually education rarely occurred in France. With the advent of AIDS, the French began teaching sexuality education as disease prevention.[54]

Most sexuality discussions in schools begin around the age of nine, and at 13, students get the nationally mandated program. The national curriculum contains five chapters dedicated solely to STDs and HIV/AIDS. Most of the sexuality education starts with questions raised by the students.[39] Biology instructors cover reproductive anatomy and physiology and invite community specialists or volunteers from family planning agencies to discuss other issues with the youth. Some topics are seldom discussed in French schools.

The HIV/AIDS epidemic provided an opening for family planning organizations to work in the schools of this largely Catholic nation and allows presenters to discuss the health concerns of young people and to address their misunderstandings. Organizations that assist in the schools include the Mouvement Francais pour le Planning Familial (MFPF), Couple et Familia, and the Regional Center for the Prevention of AIDS (CRIPS). Together, these organizations and the schools aim, not to delay sex, but to inform teens about their bodies and to assist teens to develop skills and social norms for protective sexual behavior.

In France, close ties exist among the efforts in schools, mass media campaigns, and community efforts. Schools and communities sponsor poster and scenario contests for adolescents whose creative work undergirds television, billboard, and poster campaigns. Teens from school drama programs sometimes help in developing radio spots, CDS, and music and lyrics for community-based sexuality education. Young people's questions are later used as the basis for educational materials developed for youth. Leaders in sexuality professions sponsor day-long debates on issues such as HIV infected people having babies and AIDS related suicide. Press coverage from these debates sparks classroom discussions.

Because sexuality education is nationally mandated, no French parent may withdraw a teenage student from the sexuality education program.[39] While parents may remove elementary school children, by age 13, the young person's right to information vital to personal and public health takes precedence over parental rights.

Family and Community Influences on Adolescent Sexuality

Many adults in the United States believe that sexuality education should begin in the home. Yet, evidence suggests that families provide too little sexuality education and often provide it too late. According to one study, U.S. family communication about sex includes "a few direct, sometimes forceful, verbal messages; a lot of indirect verbal messages; and a background mosaic of innumerable nonverbal messages."[55] Only 10 percent of families have any kind of on-going discussion about sex, and a significant majority of young people and parents report dissatisfaction with the quantity and quality of family discussions about sexual issues.[55]

When a national sample of parents was asked how often they talked with their children about sex, 54 percent reported never, 28 percent said rarely, and five percent said about once a year. Those parents who reported discussing sex with their children said they did so about twice as frequently as the teens said they did. Further, while 81 percent of parents felt they got honest answers from their children about sexual issues, only 22 percent of teens agreed.[56]

In some families, youth receive the message while quite young that they should not ask questions about sexuality.[57] Teenage women report more discussions with parents about sex than do teenage males, but both genders agree that parents talk less about contraception and STDs than about dating, alcohol, and drugs.[58] Most teens who do have discussions about sexuality with a parent report having them with their mothers.[57,58] Finally, 43 percent of teenage men and 65 percent of teenage women say they have no talks with their fathers about sexuality.[57] Many teens believe that adults give inadequate information about birth control because adults: 1) think teens cannot make their own decisions; 2) tell teens things too late; 3) do not listen and want to do all the talking; and 4) talk about things irrelevant to the situations teens actually deal with.[58] In one recent poll, over half of young people surveyed say there are times when they want to talk with their parents about sexuality issues but feel they will not be understood or that their parents are too busy to listen.[59]

Parents acknowledge that they are ill prepared to discuss sexuality issues with their children—84 percent in one survey said they need help while 54 percent in another survey reported being unsure what to discuss with their children about HIV/AIDS.[1,60] At the same time, parents in nine out of 10 U.S. families understand that teaching the facts about contraception increases the use of protection among teens who are already sexually active.[1]

Although many parents believe that they lack guidance for talking with young people about sexuality, several national and community-based organizations

provide and support such programs. For example, every October since 1980, *Let's Talk Month* has encouraged parents to become their children's first sexuality educators. National organizations—such as Advocates for Youth and Planned Parenthood Federation of America (PPFA)— as well as state and local coalitions have developed and presented parenting programs on sexuality education. Unfortunately, most of these programs are not well attended, and the people who attend may not be the parents in the greatest need of such classes.

Communities continue to provide the strongest efforts to prevent teen pregnancy and STDs in the United States. Local affiliates of the Young Women's' Christian Association (YWCA), Young Men's Christian Association (YMCA), and Girls Incorporated provide after school programs for youth as well as programs especially for teenage parents. Although many of these programs are actually designed to increase life options for young people rather than to deal specifically with sexuality, some of the programs have been effective in delaying first intercourse and increasing the use of contraception among sexually active youth.[61, 62,63]

Other effective life options and youth development programs, replicated in communities around the United States, include Teen Outreach Program (TOP) and the Adolescent Pregnancy Prevention Program of the Children's Aid Society. TOP has demonstrated lowered rates of teen birth, course failure, and school dropout while the other program has demonstrated delayed first intercourse, increased use of contraception, and reduced adolescent births.[61,62,64] Two community-based models that have shown promise include School/Community Sexual Risk Reduction,[65] currently being replicated at several sites in Kansas, and the Plain Talk Initiatives,[66] currently implemented in five cities. In addition, national organizations—such as Advocates for Youth, PPFA, the Sex Information and Education Council of the U.S. (SIECUS), and the recently created National Campaign to Prevent Teen Pregnancy—also provide technical support and assistance for state and local coalitions in teen pregnancy prevention program design and implementation.

Some sexuality education programs, such as *Sex Respect*, focus on the dangers of sex and its negative consequences, as well as its supposed psychological and emotional risks.[67,68] Despite inconclusive or negative findings from evaluations of such abstinence-only or abstinence-until-marriage programs,[61] many conservative organizations, such as Focus on the Family, the Family Research Council, Citizens for Excellence in Education, and Concerned Women of America, provide strong support for these programs.

In the United States, parents and communities want youth to be sexually healthy, and teens want accurate information, accessible services, and discussions with their parents. Parents know that discussions with their children about sexuality are important; but, most parents are uncomfortable discussing

sexuality with youth and uncertain how to do so. At the same time, several studies show that most U.S. residents support sexuality education for teens that teaches both abstinence and safer sex.[69,70] While some communities support abstinence-until-marriage education, other communities promote balanced, realistic education—abstinence plus contraceptive and safer sex education. Overall, communities and families in the United States disagree or feel uncertainty as to the best means to promote adolescent sexual health.

Key to attitudes about sexuality in the Netherlands is the view that decisions about sexual behavior belong to the individual rather than to community, church, or family. To support this individual ethic, the community as a whole has a responsibility to provide open, honest, and complete education that can empower the individual to avoid irresponsible and unprotected sexual behavior.[47,71] Open and frank depictions of sexuality in the media are reinforced by equally open and frank discussions in peer groups, schools, medical practices, youth agencies, and families. This individual ethic requires that parents and others support young people in fostering communication and healthy relationship skills. The Dutch see these skills as key to reducing sexual risk among adolescents. Parents accept that their young people will probably become sexually active during their later teen years, and they openly discuss sexuality and sexual behavior with their children.[47,72]

Most adults in the Netherlands expect young people to progress from peer friendship groups to a phase of being attracted to potential partners, then to a phase of sexual experimentation during which teens form a series of short-term relationships that may or may not include sexual intercourse, to the final phase of seeking long-term emotionally committed relationships. Most Dutch parents also understand that experimentation is a natural and healthy part of adolescent development.[2]

In street interviews with Dutch parents, study tour participants learned that parents are usually uncomfortable watching their teens experience these phases but also want teens to have a positive outlook on sexuality and to become sexually healthy adults. *Restrictive permissiveness* describes the approach most Dutch parents take with their teens—trying to pace their youth in their sexual development and encouraging them to be informed about all issues and to seek information from many sources. Most Dutch parents expect their teens to use birth control.[2]

In the Netherlands, most parents provide support from a distance and give teens permission to ask questions without incurring either judgment or consequences.[2] Few adults attempt to scare youth about sex. Instead, most adults focus on sexual choice and, therefore, give adolescents rights, respect, and responsibility.[72] Relatively few Dutch parents set age limits for teens to begin dating or become sexually active. In one study, many Dutch parents reported forbidding nothing; however, 50 percent of the parents reported providing guidelines about love,

serious relationships, and safer sex. Another 30 percent of the parents indicated that they believe sexuality to be a private matter and that they trust their teens to make good decisions. Finally, 20 percent of parents encourage their children to experiment during adolescence. Most parents, however, also reported hoping their young people will not date too early or experience sexual intercourse before they are ready.[72]

In Germany, the positive influences of public education campaigns are reinforced by the sexuality education that youth receive from their parents, most of whom regard sexuality as a natural part of human development. In recent decades, the German courts, the Ministry of Education, and laws regarding schools have all made sexuality education the primary responsibility of parents even though previous studies indicated that sexuality education received at home was often inadequate.[50] A recent survey indicates that parents consider sexuality education an important preventive measure.[73]

In a recent random sample of German parents, 74 percent indicated that they would not be opposed to a teen, under 18 but in a steady relationship, having sexual intercourse—with the use of contraception. In fact, 67 percent of the parents would allow their teens to have sexual intercourse in the family home.[20] Generally, German families and communities support delaying first sexual intercourse. In one study, many teens reported wanting to remain abstinent because they felt too shy or too young, had no interest yet in sex, or had not found the right person.[74] In another study, although some parents reported discussions about sexuality with their children, 90 percent of parents reported that they would like the schools to provide such instruction.[34]

Regarding parent-child communication, a survey among approximately 3,000 parents and 3,000 of their 14- to 17-year-olds found that:

- 73 percent of daughters and 53 percent of sons reported receiving sexuality education from their parents.
- 69 percent of daughters and 49 percent of sons reported their mothers as the most important source of information.
- Parents discussed different subjects depending on the teen's gender. More discussions were held with daughters in every subject area.
- Both genders received information about reproductive anatomy, contraception, and STDs. Sexual practices, homosexuality, and masturbation were less frequently addressed.
- Parents of lower socioeconomic status and more conservative parents were less likely to discuss sexuality and more likely to leave sexuality education to the schools and other sources.[73]

Various community efforts work to help parents become better sexuality educators of their own children. ProFamilia provides clinical services, counseling, and sexuality education. Staffed with educators, social workers, counselors, and doctors, the 150 ProFamilia centers throughout Germany provide support to parents and teachers, leading skills-building and educational sessions. Other German organizations also provide community-based sexual health programs. For instance, the *Love Tour* is a mobile sex education project, sponsored by the German Red Cross and FCHE. It travels throughout eastern Germany to reach youth in need of services and information in such environments as discos, clubs, and festivals.

Information about the influence of the family and community on adolescent sexual attitudes, behaviors, and health is somewhat limited in the French scientific literature. One study found that 60 percent of French adults consider sex a private matter and are reluctant to discuss it.[74] The French people value individualism and respect young people's right to make decisions regarding their sexuality. Parents provide little sexuality education; in fact, most French parents do not feel comfortable talking with their teens about sexuality issues. [39] In street interviews with citizens in Paris, study tour participants learned that most respondents do not discuss sexuality in their homes or in the homes of their friends.

Lack of openness about sexuality in families is attributed to the French culture's placing a high degree of responsibility on the individual and respecting the individual's privacy. While most French parents assume that adolescents will be sexually active before marriage, they do not explicitly encourage or permit it. Communities, therefore, place great emphasis on sexuality education occurring within community and social contexts.[74]

Sexuality education and programs supporting safer sex practices are widely available to youth within most communities. The Documentation Centre of the Mouvement Francais pour le Planning Familial (MFPF) and the Regional Center for the Prevention of AIDS (CRIPS) work cooperatively to protect the rights of people to be informed and protected from STDs, HIV, unintended pregnancy, sexual exploitation, and sexual abuse. MFPF, operating with 66 associations throughout the country, is popular with young people for education and reproductive services. On Wednesday afternoons, when French teens are out of school, clinicians, counselors and educators are available for walk-in as well as previously scheduled appointments. Further, medical and educational resources are free to young people under age 18.

To support adolescent sexual health, the French rely heavily on mass media combined with community outreach. Early and open communication is established through mass media campaigns. Many young visitors to MFPF's Wednesday clinics—designed especially for teens because schools dismiss early—come because of

mass media or word-of-mouth advertising. These clinics are teen friendly, and providers work to adapt their services to the developmental level of the clients. After-hours answering machines provide information on alternative services as well as how to access and use emergency contraception. On holidays like New Years Eve, some clinics remain open all night to help adolescents in crisis situations.

Established religion plays an important role in the lives of residents of the United States, and religion is frequently important in transmitting values, including those related to sexuality, reproduction, and families. While many religious institutions support contraception and the right of women to choose abortion, others forbid abortion and contraceptive use. In the United States, the religious right—a political movement whose motive is to create public policy with a particular religious agenda and call it "morality"—has a strong role in the creation of many abstinence-only or abstinence-until-marriage programs and in the formation of the conservative organizations that embrace them. The processes in the United States, has successfully placed supporters on school boards, county governing boards, and in state legislatures and twists public policy to further a religiously-based agenda that is at odds with the wishes and attitudes of most citizens of the United States.

By contrast, in the Netherlands, Germany, and France, residents generally do not consider established religion relevant to values related to sexual and reproductive health. Collective force, such as church dogma or legislative dictum, does not determine the morality of sexuality in any of the three European countries. Instead, individual freedom and responsibility form the foundation of an ethic by which a person weighs the morality of his or her sexual behavior. That ethic includes the values of responsibility, love, respect, tolerance, and equity.

The Lessons Learned: Summing It Up

In the European nations studied, a major public health goal is to ensure that everyone, including adolescents, has the necessary skills to behave responsibly when sexually active. Consequently, major efforts go into developing and delivering effective mass media campaigns. Mass media play an important role in educating entire populations as well as shaping perceptions and behaviors. In each of the three countries visited, mass media promote more open and frank discussions about sexuality than existed before. Dutch, German, and French experts believe such discussions contribute to the acceptance of sexuality as a normal and healthy component of life for everyone.

The Netherlands, Germany, and France target *all* sexually active residents with messages to have safer sex. In general, their campaigns encourage specific sexually healthy behaviors and do not stress fear or shame. They show people in pleasurable relationships. The messages are generally engaging and appealing. They present images and concepts that relate to sexuality in a sensual, amusing, or attractive way.

In all three European nations, great value is placed on individual ethical behavior in choosing sexual health and responsibility, and none of the three nations appears to value collective force to motivate behavior. The responsibility placed on each individual, regardless of age, to act ethically in making sexual choices then creates in each society a community responsibility to ensure that everyone has the knowledge and health services needed to support those choices.

In all three nations, adults encourage teens to be responsible about sex. National health care in each country covers the costs of most forms of contraception, emergency contraception, abortion, counseling services, physical exams, screening, and treatments. Condoms are inexpensive and widely available. All levels of health care personnel, including those staffing front desks, work hard to reduce or remove barriers that deter young people from getting needed health services and to establish and maintain a high degree of trust between young people and health practitioners. Educators, media professionals, and communities collaborate to motivate young people to recognize the benefits of responsible sexual behavior and to acquire and use contraception.

In the Netherlands, Germany, and France, sexual development in adolescents is seen as a normal and healthy biological, social, emotional, and cultural process. Education focuses on informed choice and sexual responsibility for all members of the society, including adolescents. Public campaigns coordinate with school sexuality education, condom and contraceptive access, and nonjudgmental atti-

tudes from adults to protect sexual health. Scientific research drives sexuality-related public policies in all three nations.

In the schools, no sexual health topic is prohibited, and teachers are free to teach in response to students' questions. No topics are too controversial if young people want to discuss them. Public and private schools in the Netherlands and Germany acknowledge that sexuality education is important and concentrate it most heavily in middle and secondary years. While sexuality education is taught as a specific health unit in Germany and France, it is also widely and naturally integrated wherever it is relevant—in literature, languages, social studies, religion, sciences, or current events in all three nations. The teaching is a collaborative effort among school personnel, community youth workers, reproductive health clinicians, parents, and communities.

In the three European countries, parents and communities accept youth as sexual beings and accept sexual intercourse as a logical outcome in intimate relationships. Most adults in these three nations do not see teenage sex as a problem so long as protection is used. Parents in the Netherlands, Germany, and France want young people to develop a healthy sexuality and support both abstinent and sexually active teens in making responsible decisions. Dutch, German, and French parents use multiple channels to ensure that teens are well informed and socially skilled and may provide teens with condoms and contraception to protect themselves. Parents then trust teens to make good choices for themselves and to be responsible.

The United States provides few consistent, continuous, effective mass media campaigns promoting healthy sexuality. Many barriers deter U.S. teens from accessing contraception including high costs, pelvic exams, limited clinic hours, disapproving adults, and fear that parents will find out. Politics, not research, usually dictates the content of sexuality education programs and creates a climate in which important personal and public health services may be withheld from teens.

Many parents do not provide their children with as much honest, open communication regarding sexuality as the young people need. Teens receive little parental and community support or information about respect, intimate relationships, responsible decision making, and using protection in sexual relationships. Some teens in the United States feel alienated from their families and communities and have little motivation to protect themselves or their sexual partners.

Another fundamental difference is how teen sexual behavior is defined. This difference profoundly affects how families, communities, and nations address adolescent sexuality. In the Netherlands, Germany, and France, teen sexual behavior is a developmental and public health issue. The consensus about this demands family and community support and all adults' having a role in communicating with teens about prevention and protection. Teen sexual behavior in the United

States is viewed in many contexts: a moral failing, a political issue, a private family matter, or a public health concern, but seldom as a developmental matter. These multiple perspectives create a confusion of efforts at all levels and provide a backdrop for competing and conflicting messages to U.S. teenagers.

The lessons learned by the European Study Tour in the summer of 1998 can have valuable implications for U.S. efforts to improve the sexual health of adolescents.

- The Dutch, Germans, and French view young people as assets, not as problems. They value and respect adolescents and expect teens to act responsibly. Governments strongly support education and economic self-sufficiency for youth.
- The morality of sexual behavior is weighed through an individual ethic that includes the values of responsibility, love, respect, tolerance, and equity. The morality of sexual behavior is not the result of collective force, such as religious dogma.
- Families, educators, and health care providers have open, honest, consistent discussions with teens about sexuality.
- Adults see intimate sexual relationships as normal and natural for older adolescents, a positive component of emotionally healthy maturation. Young people believe it is 'stupid and irresponsible' to have sex without protection and use the maxim, 'safe sex or no sex.'
- Marriage is not a criterion for intimate sexual relationships for older adolescents.
- The major impetus for improved access to contraception, consistent sexuality education, and widespread public education campaigns is a national desire to reduce the numbers of abortions and to prevent HIV infection.
- Sexually active youth have free, convenient access to contraception through national health insurance.
- Sexuality education is not necessarily a curriculum; it may be integrated through many school subjects and at all grade levels. Educators provide accurate and complete information in response to students' questions.
- Governments support massive, consistent, long-term public education campaigns utilizing television, films, radio, billboards, discos, pharmacies, and health care providers. Media is a partner, not a problem, in these campaigns. Sexually explicit campaigns arouse little concern.
- Research is the basis for public policies to reduce pregnancies, abortions, and STDs. Political and religious interest groups have little influence in public health policy.

Call to Action

Advocates for Youth calls for a new national dialogue on adolescent sexual health, focusing on respect, rights, responsibility, and research.

Given both the high rates of teenage pregnancy and sexually transmitted diseases in the United States and the lessons learned in the Netherlands, Germany, and France, Advocates for Youth calls for a new national dialogue on adolescent sexual health that recognizes sexuality as a normal, healthy component of human growth and development and that has, as its core philosophical tenets: 1) respect for all adolescents as valuable individuals, 2) recognition that teens have the right to receive accurate, complete sexual health information and health services, and 3) acceptance that young people, like adults, have the responsibility to protect themselves and their partners from unintended childbearing and sexually transmitted diseases (STDs). Advocates for Youth calls on all policy makers, educators, parents, clergy, clinicians, and media professionals to insist that sexual health policies be driven by research—not by politics or religious dogma.

Sexuality and the expression of sexual feelings are normal, healthy components of adolescent growth and development. Sexual feelings should not provoke shame, and information about sexuality should not provoke fear. Adolescents have questions about what is normal, and they need to learn the skills that will help them develop and sustain loving, rewarding, committed, intimate relationships over the course of their lives. Open, honest dialogue about sexuality and sexual development can help U.S. teens, like their European counterparts, better prepare to create committed relationships and to protect themselves and their partners from unintended pregnancy and STDs.

All adolescents deserve <u>respect</u> as valuable individuals.

Every single adolescent is a valuable individual who deserves the respect and support of family, community, and society. Adults need to view young people as assets rather than as potential problems. Each adolescent has opinions, feelings, and experiences that matter. Each has a unique contribution to make. Young people should be encouraged to get involved—to make a difference in the world. Families, communities, and society should act so that young people appreciate and develop their individual talents and value both themselves and others. Society demonstrates that it values young people by providing them with good quality education, economic security, and the promise of fulfilling futures.

Every young person has the right to the information and services necessary to make responsible decisions about his or her reproductive and sexual health.

Adolescents, like adults, have the right to complete, honest, and accurate reproductive and sexual health information. Adolescents, like adults, have the right to accessible, affordable, and quality health care services. Confidentiality is critical in this sensitive area, for taking away a young person's privacy also takes away access to care. Parents can be most supportive by creating open, loving, and respectful relationships with their children.

Rights entail responsibilities.

Families, communities, and society have a responsibility to provide young people with the support they need to create healthy, fulfilling lives. Adolescents, in turn, have the responsibility to act upon the information and services available to them. The right to information and health services comes with the responsibility to protect oneself and one's partner against unintended pregnancy and STDs, including HIV.

Research must dictate public policy.

Public policies that impact the health and the well being of young people should rest securely on scientific research. Adolescents deserve sexual health strategies based upon best practices as determined by evaluation and research. Science—not politics or religion—should drive public health programs and policies.

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