

European Approaches to Adolescent Sexual Behavior & Responsibility



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Washington, DC

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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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This monograph presents the findings of the European Study Tour. The views expressed herein should not be construed to reflect those of either the funders or all study tour participants.

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Preface

The Summer Institute, sponsored by Advocates for Youth and the University of North Carolina at Charlotte, is a six credit hour graduate course, taught at the university. Begun in 1993 by Linda Berne, Ed. D., Professor of Health Promotion and Kinesiology at the University of North Carolina at Charlotte, and Barbara Huberman, M.Ed., Director of Training and Sexuality Education at Advocates for Youth, the Summer Institute trains youth workers, educators, and health care providers. Its goals are to increase knowledge about adolescent sexuality, advocacy and community organizing and to enhance the skills of sexuality educators.

In the summer of 1998, the Institute was organized as a two-week study tour to the Netherlands, Germany, and France to determine how these nations address issues of adolescent sexuality. Twenty-eight U.S. experts in adolescent health, two teen journalists, and 12 graduate students participated in the study tour.



1998 European Study Tour Participants

Participants included: Roxann Barnes, educator; Linda Berne, Professor of Health Promotion at the University of North Carolina at Charlotte; Peggy Brick, author and Director of Education for Planned Parenthood of Greater Northern New Jersey; Amy Brugh, graduate student; Dominic Cappello, media designer and trainer; LaTonya Chavis, graduate student; Laura Davis, Director for Adolescent Pregnancy Prevention at Advocates

for Youth; Renee DeMarco, International Division Director at Advocates for Youth; Shelley Evans, Peer Education Program Coordinator; Ammie Feijoo, graduate student and Program Associate for Legislative Affairs at Advocates for Youth; LaCole Fender, graduate student; Darryl Figueroa, Director of Communications at Advocates for Youth; Evangeline Freeman, social worker; Candy Hadsall, registered nurse and consultant; Gail Harding, Director of Family Life Education for the New York Department of Education; Melissa Harris, student reporter for *Teen People*; Renee Hauser, graduate student; Kendra Hollinger, graduate student; Barbara Huberman, Director of Training and Sexuality Education



Teen participants Melissa Harris and Kaneia Mayo.



Dr. Linda Berne

at Advocates for Youth; Dawn Jacoby, graduate student; René Jones, graduate student; Marjorie Kelly, Professor at Kean University; Maureen Kelly, graduate student and Director of Education, Planned Parenthood of Ithaca; Roberta Knowlton, Director of School-Based Youth Services, New Jersey; Evelyn Lerman, author of books on teens sexuality; Jeanne Lindsay, author and publisher of books on adolescent pregnancy and parenting; Kaneia Mayo, student reporter for Children's Express; Ebuni McFall, graduate student; Michael McGee, Vice President for Education at Planned Parenthood Federation of America; Townley Moon, Director of the Mecklenburg Council on Adolescent Pregnancy; Mary Lou Moore, Professor at Wake Forest University; Myra Morgan, graduate student; Bonnie Parker, Director of Education at HITOPS; Lynn Pike, Associate Professor at the University of Missouri; Theresa Pollock, graduate student; Lynne Robinson, Assistant Professor, the University of North Carolina at Charlotte; Molly Rodgers, Director of Youth Services, Community Action Agency; D. Chan Roush, graduate student; Jan Stanton, Director, Heart to Heart; Shannon Swift, health educator; James Wagoner, President of Advocates for Youth.

The Henry J. Kaiser Family Foundation provided funding for the participation in the study tour of the two teenage journalists. Advocates for Youth provided funding and support for six participants, the syllabus, and all general expenses of coordinating and conducting the study tour. Some participants received assistance from their local communities, private funders, and research stipends.

The study tour's sponsors and leaders profoundly appreciate the extensive assistance of the following individuals, without whom this study tour could not have taken place: Joel Gallegos, University of North Carolina at Charlotte, Office of Education Abroad; Toon Dijkstra, Program Director, European Orientation Center, KPC Group, the Netherlands; and Dr. Jany Rademakers, Research Coordinator, NISSO, Utrecht, the Netherlands. In addition, Advocates for Youth is deeply grateful for the expert assistance of professionals in the Netherlands, Germany and France who constituted the European faculty for study tour participants.



(l. to r.) Dr. Jany Rademakers, Ann Marie Servant, Regime Schirrer, and Bertrand Sachs.

The study tour's sponsors and leaders are grateful for the time and valuable assistance of the following experts from the Netherlands: Janita Ravesloot, Faculty of Social Science, Youth Studies and Youth Policy at Leiden University; Jos Heinen, GG-GD STD Clinic, Amsterdam; Peter Van Deven, KPC Group, Hertogenbosch; Dr. Raymond le Clercq, Stang; Mies Vandam, Aletta Jacobshuis; Ann Marie Broeders, Stichting SOA-besnyding, Utrecht; Dr. Marijke Albas, Bourgognekliniek, Maastricht; Father De Jong, University of Maastricht, St Servaas Church; Doortje Bracken, Rutgers Foundation, Utrecht; Maria Schopman, SR-70, Amsterdam; Ninette Van Hasselt, Stichting SOA-besnyding, Utrecht; Dr. Gerald Roelofs, RIAGG, Maastricht; and Hank Geelen, SCOOP, Maastricht.



(l. to r.) Barbara Huberman and Toon Dijkstra, European Orientation Center, KPC Group, the Netherlands

The study tour's sponsors and leaders deeply appreciate the time and valuable assistance of the following experts from Germany: Frau H. Rehman, Federal Center for Health Education, Koln; Stefanie Amann, Federal Center for Health Education, Koln; Harold Lehmann, Federal Center for Health Education, Koln; Frau Katja Uhlig, ProFamilia, Dusseldorf; Dr. Wolfgang Muller, Federal Center for Health Education, Koln; and Dr. H. Boecker-Reinartz, ProFamilia, Dusseldorf.

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James Wagoner and Laura Davis at KPC Center.

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.

A handwritten signature in black ink that reads "James Wagoner". The signature is written in a cursive, flowing style with a large initial 'J'.

James Wagoner,
President, Advocates for Youth

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. 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. The teens of Germany and France experience first sex at 16.2 and 16.8, respectively.

While teen condom use is fairly consistent among the four nations, 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. In Germany, about 63 percent of sexually active adolescent females report using oral contraceptives at most recent intercourse. By contrast, 20.5 percent of sexually active adolescent females in the United States report using oral contraceptives at most recent intercourse. Less use of effective contraception and the earlier onset of sexual activity put U.S. teens at greater risk for negative outcomes.

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

In the schools of these three nations, no 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.

A fundamental difference that emerges between the United States and the three European countries is in the influence of religious groups on public policy. In the European nations, public policy about sexuality and sexual health is more often dictated by pragmatism and research than it is in the United States, where a history of puritanism underpins conflicting attitudes about sexuality and provides

an opportunity for the Religious Right to derail research based public policy, substituting instead, a conservative, religiously-based agenda. This agenda, cloaked as “morality,” undermines public health efforts to promote safer sexual behavior and is at odds with research and with the attitudes and wishes of most U.S. adults. The emphasis in the United States is, too often, on collective force—such as legislatively mandated parental consent requirements or abstinence-until-marriage education—rather than on individual responsibility to make ethical behavioral choices.

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.

Chapter 1

Setting the Stage: Adolescent Sexual Health Indicators in the United States, the Netherlands, Germany, and France

The Summer Institute for Family Life Education and the 1998 European Tour

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 nationally recognized Summer Institute, a six-credit graduate course, begun in 1993 to provide youth work professionals, teachers, and health care providers with increased knowledge about adolescent sexuality, advocacy, and community organizing and to enhance their skills as sexuality educators.

In 1998, the Institute initiated an international fact-finding mission to the Netherlands, Germany, and France, chosen because of their low teen birth, abortion, and HIV infection rates. The study tour explored how these European nations have successfully improved 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.

Participants prepared for the study tour by studying peer-reviewed research and background data about adolescent sexuality in the selected countries and the United States. The more than 90 articles studied gave each participant a strong background for meetings with European experts.

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. The issue areas and the public policies relating 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 as they impact adolescent sexual behavior.

During the 16-day study tour, participants listened to expert presentations, participated in panel discussions, and visited adolescent health and educational facilities. They spoke, as a group and individually, with clinicians, religious leaders, sexologists, teachers, outreach specialists, social marketers, and media specialists. The European experts included researchers, government officials, medical professionals, school administrators, media professionals, and agency leaders. Working in pairs, participants also conducted informal street interviews with parents and young people in each nation.



Dom Cappello discusses what has been learned.

Periodically throughout the trip, participant debriefings permitted discussion and comparison of research findings and impressions about each country. Following the study tour, the graduate students submitted extensive research reports on each issue area. This document synthesizes the research reports and data from the Netherlands, Germany, and France, and presents the lessons learned about European approaches to adolescent sexuality and sexual behavior and its consequences.

This chapter provides demographic profiles of the Netherlands, German, France, and the United States, using comparative data and rates related to the sexual and reproductive health of young people in each country. Following chapters present in-depth analyses of each of the issue areas. Because public policy is interwoven with each issue area, observations about policies are integrated throughout the chapters.

Demographic and Sexual Health Comparisons of the United States, the Netherlands, Germany, and France

Population, Race, and Ethnicity

Two factors largely differentiate the United States from the other three nations: population size and cultural diversity. The United States, the most culturally and geographically diverse of the four countries, has approximately 263 million people in a land mass slightly smaller than Europe¹; the United States includes largely rural plains and deserts, heavily populated coast lands, and many cultures. The Netherlands, Germany, and France—with populations of approximately 15, 81, and 58 million people, respectively— together have a land mass about the size of Texas (although more densely populated).¹ Further, the three European nations have largely homogeneous cultures and populations.

Table 1 presents the percentage of the population in each country that is foreign born. Almost 20 percent of those living in the United States are immigrants, compared to some 10 percent of those living in Germany and five percent or less of those living in the Netherlands or France.¹ Germany has the unique challenge of reweaving its country and citizens into a unified whole after almost 40 years of division into two cultures and countries; it also has immigrants from Turkey, Italy, Greece, Yugoslavia, and the former Balkan and Soviet Union states. By contrast, France and the Netherlands have mostly homogeneous populations, although France is now adjusting to a sizable influx of immigrants from North Africa and the Netherlands to immigrants from Turkey, Morocco, Suriname, and the Netherlands Antilles.^{1,2} Youth, ages 13 to 19 account for 11 to 14 percent of the population in each of the four nations.⁹

Demographics of the United States, Germany, France and the Netherlands¹

Nation	Population	Foreign Born Population	Adolescent Population
United States	262,755,270	20 percent	14 percent
Netherlands	15,382,830	4 percent	12 percent
Germany	81,421,960	9 percent	11 percent
France	57,526,521	5 percent	14 percent

Table 1

Although the population of the United States remains largely of European descent, the cultural differences between those descended from Scandinavian, English, Irish, Italian, and Greek immigrants (to name but a few) may remain evident after several generations. Nearly five percent of the American population is Asian/Pacific Islander and Native America, while some 12.5 percent is African American, and nearly 11 percent is Latino.³ The United States is currently experiencing a rapid cultural shift due to growth in the African American population and a large influx of Latinos from Central and South America. By the year 2010, population experts forecast that half of children in U.S. public schools will be Latino or African American.⁴

The United States has the highest poverty level among major industrialized nations.⁵ In measuring poverty in industrial economies, U.N. analysts look at longevity, literacy, disposable income below 50 percent of the median, and long-term employment. By those measures, the United States earns a 16.5 percent poverty score; by comparison, the Netherlands' score is 8.2 percent, Germany's is 10.5 percent, and France's is 11.8 percent.⁵ These scores are significant in that poverty is too often a predictor of unequal academic and economic opportunity, of risk behaviors, and of teenage childbearing.⁶

Religiosity

The Dutch are 22 percent Protestant, 32 percent Catholic, and seven percent Muslim, Jewish, or others; 40 percent claim no religious affiliation; 74 percent of Dutch residents are nonparticipating in their religion.⁷ In Germany, 45 percent of the population is Protestant, 37 percent Catholic, and 18 percent other; meanwhile, 18 percent of those who identify themselves as belonging to a religion are only nominally affiliated with any church.⁸ Seventy-six percent of France's population is Roman Catholic; 22 percent of French residents claim another religious affiliation.⁹ In the United States, 55 percent of the population report being Protestant, 30 percent Catholic and 7 percent Jewish, Muslim or other.⁹ Of the four nations, only the United States has a strong Fundamentalist Protestant movement, grown over the past two decades to become entrenched at all levels of politics. Fundamentalism appears to have little presence and no public voice in the Netherlands, Germany, or France today.

Sexual Behavior

International research shows that the age of puberty has fallen since the turn of the century in all industrialized countries and has stabilized over the past 20 years.¹⁰ The median age of puberty—which marks the onset of the ability to reproduce—occurs on average at 12.2 to 12.8 years in girls and 13.5 to 14 years in boys.^{10, 11} Experts disagree about the extent of the decline over the past century, but records show that girls typically experienced puberty at about age 15 to 16 and boys between 15 and 17 at the beginning of the 20th century.^{10, 12} Experts attribute the decline in the age of puberty to better nutrition and increased body fat in children in the developed world.¹⁰

Industrialized nations also have exhibited a universal rise in the age of first marriage. Figure 1 shows that the median age of marriage has risen in the United States from an average of 22.9 in 1920 to 25.9 in 1997. While a trend toward cohabitation rather than marriage is evident in all four nations of this study, it is particularly evident in the Netherlands.^{3, 9, 10}

Age of Puberty and Median Age of Marriage for Men and Women^{13,14} Trends from 1910 to 1998

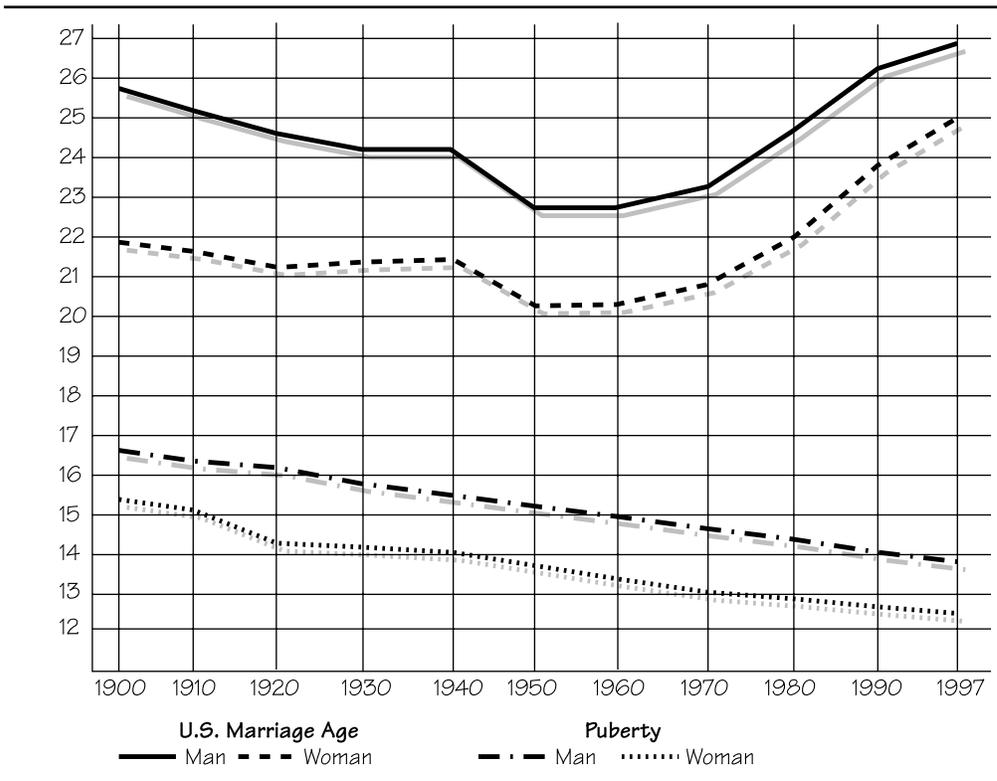


Figure 1

Table 2 provides the average age at first sexual intercourse among the four nations. U.S. teens are the youngest—at an average age of 15.8—to experience first sexual intercourse.¹⁵ Teens in the Netherlands—which exhibits the most liberal attitudes about sexuality and sexual behavior—experience first intercourse at the latest average age, 17.7.¹⁶ The teens of Germany and France experience first sex at 16.2 and 16.8, respectively.^{15,16} Surveys demonstrate that the age of first sexual intercourse is declining throughout the world.

Age at First Intercourse^{15,16,17,18}

Nation	Average Age at First Intercourse
United States	15.8
Netherlands	17.7
Germany	16.2
France	16.8

Table 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.¹⁶

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.¹⁹ In Germany, 56 percent of sexually active male teens used condoms at first intercourse, remaining about the same at 57 percent at most recent intercourse.²⁰ Condom or other contraceptive use at first vaginal intercourse increased to 54 percent among young women.²¹ Among sexually active U.S. teens, 65 percent reported using a condom at most recent intercourse.^{17,22} 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.²³

In the United States, condom and contraceptive use among teens varies by race, gender, socioeconomic status and other factors; Latino teens are the least likely to use contraception, and teens of European descent are more likely to use contraception than are other U.S. teens.¹⁷ Recent U.S. data indicate that condom use peaks at age 15 to 16, when between 70 and 80 percent of sexually active male teens use condoms at most recent or at every act of intercourse and drops off among 18- and 19-year-olds.²⁴ Condom use decreases among older teens in the United States. Among sexually active male teens in the United States, 29 percent of Latinos, 46 percent of whites, and 47 percent of African Americans report consistent condom use during the last year.²⁴

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.²⁵ In Germany, about 63 percent of sexually active adolescent females report using oral contraceptives at most recent intercourse.²⁰ By contrast, 20.5 percent of sexually active adolescent females in the United States report using oral contraceptives at most recent intercourse.²²

Table 3 presents the rates of teen birth and, when available, abortion by country. The most noticeable difference is the much higher rates of teen birth and abortion in the United States as compared with the other three nations. In 1996, 54.4 of every 1000 women ages 15 to 19 in the United States bore a child— 491,577 infants.²⁶ The United States' adolescent fertility (or birth) rate is four times higher than Germany's rate of 13 per 1000^{27,28} and the majority of German teenage mothers are residents of the former East German states or are immigrants. The Netherlands has the lowest confirmed teen fertility rate in the world—6.9 per 1000 women ages 15 to 19.^{19,29} While teen abortion rates are not available for Germany and are estimated for some U.S. states, it appears that the abortion rate for U.S. teenagers is more than double those of the comparison countries.

Live Birth (Fertility) and Abortion Rates^{19,27,29,30}
per 1,000 Women Ages 15 to 19

Nation	Birth Rate	Abortion Rate
United States	54.4	17
Netherlands	6.9	5.2
Germany	13.0	Unavailable
France	9.1	7.9

Table 3

AIDS case rates are reported for all four countries in Table 4. The United States, with the largest number of reported cases in the industrialized world, and France with the largest number of reported cases in Europe, also have case rates considerably higher than those of the Netherlands and Germany. Again, these case rates provide strong evidence that a significant proportion of the U.S. population, including adolescents, is engaging in unprotected sex.

AIDS Case Rates in the General Population³¹

Nation	AIDS Case Rate per 100,000 population
United States	2.33
Netherlands	.28
Germany	.20
France	.75

Table 4

The U.S. Centers for Disease Control and Prevention (CDC) estimates that sexually active teens in the U.S. contract about 3,000,000 new STD infections each year. Chlamydia, newly reportable to the CDC, causes pelvic inflammatory disease, infertility, and ectopic pregnancy; the U.S. case rate of chlamydia in adolescent women ages 15 to 19 was 2,068.6 per 100,000 population in 1996.³² Because of the severe health consequences of chlamydia, some U.S. physicians are now calling for all sexually active females to be screened regularly for it.³³

Although STD incidence data are not available for all four nations and comparable population groups, gonorrhea and syphilis case rate comparisons between the United States and Germany suggest that some STD rates may be much higher in the United States than in the European nations. In 1996, the United States experienced an overall gonorrhea rate of 124 per 100,000 population and a syphilis rate of 4.3 per 100,000 population.³² By comparison, Germany's reported rates of gonorrhea and syphilis were 5.0 and 1.4 per 100,000 population, respectively.³³ These rates were nearly 25 times and four times lower, respectively, than the U.S. rates.

Conclusion

In all four countries, adolescents engage in sexual intercourse. All four countries have experienced a drop in the age of puberty and a rise in the age of first marriage, creating a 13-year gap between these two events.

When compared to the youth of Germany, France and the Netherlands, youth in the United States initiate sexual intercourse earlier and report less use of effective contraception except condoms. Because about half of sexually active teens have unprotected sexual intercourse, the earlier onset of sexual activity puts U.S. teens at greater risk for negative outcomes. Teens in the United States have significantly higher rates of birth, abortion, and STDs than do their European counterparts.

When comparing the United States to the Netherlands, Germany and France, it is important to consider the different demographics of the four countries. Variations in religion and culture and the percentage of foreign-born residents greatly increase the heterogeneity of a nation's population. As the heterogeneity increases, differences in values, customs, and attitudes emerge. As the most diverse and decentralized of the countries studied, the United States also experiences the poorest overall sexual health indicators and exhibits a wide diversity in the same indicators by race/ethnicity and socioeconomic factors.

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Chapter 2

Media: A Partner in Sexual Health Campaigns

During the study tour, participants gathered information about media messages regarding sexuality and sexual health. They inquired whether national governments sponsor campaigns and whether those campaigns present clear, unambiguous, and long-term messages to reduce sexual risk behaviors and to encourage protective sexual behaviors. Participants also inquired into whether campaigns target specific times or events.

Participants inquired as to the paths media used to disseminate public education materials and whether young people are involved in the development, design, and creation of the materials for young people. The tour focused on whether the national governments exert centralized control over these campaigns and their content and whether the governments censored the content. The degree of cooperation by entertainment industry professionals in these campaigns was also of interest to participants, and the tour gathered information on studies supporting the effectiveness of these campaigns.

The study tour participants viewed many explicit examples of public education campaigns that were designed to send clear and unambiguous messages. They saw many examples of safer sex and sexuality campaigns, some humorous, some serious. Perhaps the most surprising information gathered related to the lack of public controversy or objections to these campaigns among the Dutch, German, and French viewing public.

Mass Media and Sexual Health in the United States

Since the sexual revolution of the 1960s, young people in the United States have received 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.” Programming frequently reinforces negative gender stereotypes.¹

A television prime time analysis conducted by Louis Harris and Associates reveals that the average adolescent in the United States views 14,000 sexual references, jokes, and innuendos each year.² However, only one in 85 of these references will mention abstinence, contraception, or marriage, sometimes negatively.³

Soap operas and television talk shows which air at times when young people may be home alone and unsupervised are 24 times more likely to intimate or discuss sex between unmarried partners than married partners.⁴ Of TV's music videos aimed at the adolescent and young adult market, 75 percent contain sexual imagery and 50 percent involve violence. Eighty percent of these videos combine both sexual and violent images, usually victimizing women.²

Table 5 shows exposure to television of U.S. youth. By age 18, the average U.S. young person will view 21 to 22 hours of television per week and listen to two to three hours of radio per day⁵—much more time than he or she will spend in school. It should surprise no one that mass media powerfully shape teenagers' attitudes, beliefs, values, and sexual behavior.

Time Spent Watching Television in the U.S. by Age and Gender

Age & Gender Groups	Time spent Watching TV Hours & Minutes per Week
2 - 11 years	23.01
12 - 17 years	21.50
Men, 18 years & up	30.41
Women, 18 years & up	34.37

Table 5

Source: A.C. Nielson Company, 1993

While media are saturated with sexual content, references to responsible sexual behavior are rare. 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; but entries are few compared to the number of sexual hints, innuendos, and scenes that encourage irresponsible sexual behavior.

In 1982, the National Association of Broadcasters lifted a ban on contraceptive advertising. Yet, most major networks still air no commercials or public health campaigns that deal with condoms, contraception, or sexual risk reduction. At one time, FOX network agreed to air condom commercials, but they could deal only with HIV prevention and were generally aired after prime time.⁶ Polls show that Americans favor contraceptive advertising and portrayals of responsible sexual behavior in the media.⁶ Yet, the networks apparently fear backlash from fundamentalist religious groups and from politicians believing that media education about protective sexual behavior will increase sexual activity in teens.

Another use of mass media is public health education campaigns which can be effective in educating people and in altering their attitudes. 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. Four 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.

In spite of the fact that it has the highest HIV/AIDS rates in the western world, the United States has provided its people with few continuous, long-term national media prevention campaigns. Further, 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. One participant observed, “Of all the media products I see, some of ours are just as good or better. We’re doing the right things—we’re just not doing enough of them on an ongoing basis and at a national level.”

On one side, media promotes sexual messages that show sex as risk-free, glamorous, and exciting. On the other side, the government promotes a national abstinence-until-marriage only policy. Both messages are unrealistic, leaving teenagers stuck in the middle and unprepared for the situations they encounter.

—Study Tour Student

Mass Media in The Netherlands

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.⁷ 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.⁸

The Netherlands' mass media campaigns do not operate in isolation. Because experts recognize the need to integrate research, media, and education, the government has funded several organizations and projects to collaborate in formulating integrated strategies for delivering safer sex messages through a variety of channels. Three important government funded organizations in the area of sexual health are the Netherlands Institute for Social Sexological Research (NISSO), the Rutgers Foundation which disseminates both information and reproductive health services, and the Dutch Foundation for STD Control.

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 and research-based theory. Continuing research 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, education, and policies.

Table 6 outlines the 12 years of strategic campaigns supporting safer sex in the Netherlands. The first campaign, "Flower and the Bee" in 1987, provided basic knowledge about AIDS and debunked myths about the rising epidemic. The second campaign encouraged use of condoms. These two public education campaigns were the first steps in changing widespread beliefs that AIDS only affects homosexuals and drug users.⁷

In 1988, agencies introduced the 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 leaflets, posters, stickers, and condoms. The brochures used several languages to help Dutch youth negotiate safer sex in the languages of potential partners. Dutch schools distributed approximately 250,000 leaflets. Intermediaries also distributed the packets at youth camps, community organizations and pharmacies throughout the country.

Strategic Mass Media Campaigns in the Netherlands on Safer Sex

Year	Campaign	Focus and Messages of the Campaign
1987	"The flower & the bee"	Brings AIDS to public attention; provides brochures at every pharmacy and doctor's office
1987	Condom campaign	Uses role models to promote condom use, but does not use the word condom.
1988	Summer campaign	Encourages teens on holiday to protect themselves
1989	Excuses campaign	Dismisses excuses not to use condoms [only worked well with those educated about HIV]
1990	Excuses campaign II	Dismisses excuses not to use condoms [for the better educated]
1993	"I'll have safe sex or no sex!"	Encourages teens to use condoms: Step 1. Fall in love Step 2. He/she feels the same. Step 3. Kiss. Step 4. Use a condom.
1994	"I'll have safe sex or no sex!" II	Encourages use of condoms for youth, elders, racially mixed couples, gays, etc.
1995	"I'll take something off if you'll put something on."	Encourages assertiveness; communication skills; assertive 'lines'
1996	"Your condom or mine?" STD top 10	Humorously encourages communication skills—"Bring it up while your pants are still on!"
1997	"Your condom or mine?" STD top 10	Continues popular 1996 campaign
1998	"STDs are available somewhere near you."	Encourages—"Always have condoms near you, too!"

Table 6

National television also aired video clips developed about condom use. Dutch teens saw the videos as they traveled on buses. The campaign acknowledged that youth have sex in holiday situations and displayed concern for their sexual health and safety rather than attempting to provide didactic messages about casual sex. The campaign's success was measured by increased condom use among Dutch youth.⁸

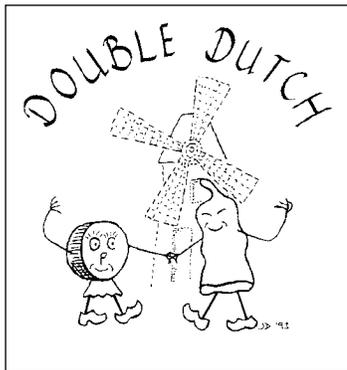
The campaigns of 1989-1991 focused on excuses for not using condoms. The commercials and posters targeted a variety of groups and levels of education. Excuses ranged from "It can't happen to me" to "I don't need a condom because I only sleep with decent girls/guys." The 1992-1994 campaigns worked to achieve changes in social norms, using social learning theory, and the theme, "I'll have safe sex or no sex." Other messages included "Be proud of having safe sex," "It's okay to have safe sex," and "Step 1: You fall in love. Step 2: She feels the same. Step 3: You kiss. Step 4: You use a condom."



The 1992-1994 series aggressively marketed condoms through advertisements. Although some religious groups expressed concern when the first condom ads appeared, they supported the campaign. 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 focused clip, “Your condom or mine?” These video clips were shown in cinemas and on TV.

The 1998 campaign produced a popular and humorous commercial. The “Too Early—Too Late” campaign featured 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. The second promotion, “STDs are somewhere near you and so are condoms,” used typical people and demonstrated the wide variety of locations where condoms are available. The campaign used posters and billboards in bus and train stations, on streets, in pharmacies and other public places.

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. With the advent of AIDS, many STD experts wanted to shift the emphasis to condom use. Others felt this approach might jeopardize the low rates of unintended pregnancy already achieved through high pill use. The compromise resulted in the “Double Dutch” message which encourages sexually active people to employ two methods of protection, the pill to prevent pregnancy and the condom to prevent STDs. Figure 2 provides an example of advertising for the “Double Dutch” campaign.



Today, 85 percent of Dutch adolescents use protection at first sexual intercourse—46 percent use condoms, 13 percent use oral contraceptives, and 24 percent use “Double Dutch”—the pill and condom together.⁹

Entertainment television programming in the Netherlands plays a role in sexuality education. In the 1990s, several sessions of a popular show called *Sex with Angela* were produced. The host, pop singer Angela Groothuizen, sat on an oversized bed with different groups of teens and talked about sex. The host handled all sorts of issues and questions, including safer sex, correct use of condoms, negotiation skills, kissing, sexual techniques, relationships, feelings, and what makes a sexual experience good or bad. Efforts such as *Sex with Angela* were intended to help the population develop positive attitudes about using condoms, create social norms for safer sexual behavior, and develop communication skills.

In 1997, the government sponsored an evaluation to determine if the public education campaigns regarding safer sexual behavior were effective. Surveyed by telephone, 1500 Dutch citizens, ages 15 to 45, were questioned to determine changes in sexuality-related behaviors. The survey found that:

- 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.⁹

While these results are impressive, they may not be entirely due to mass media campaigns as many other ongoing educational efforts have also been implemented and widely disseminated. However, by coordinating efforts, the mass media campaigns reached wide audiences through radio, television, cinemas, commercials, magazines, outdoor advertising, posters, and leaflets.⁸

In contrast to abstinence campaigns in the United States, the 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, the campaigns have targeted safer sexual behavior. Efforts in the Netherlands clearly demonstrate that appropriately targeted, research- and theory-based campaigns work when they are long-term, coordinated, implemented through multiple channels, and delivered on a large scale.



Posters and postcards: Dutch Foundation for STD control

Mass Media in Germany

The Germans have been as aggressive as the Dutch in developing and distributing safer sex messages since 1985. 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.¹⁰ Over the 13-year period, FCHE has produced 60 prevention television spots. 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.¹¹

Leaders felt that focusing on these areas would decrease public fear and enable HIV-infected persons to reintegrate into society. FCHE developed three strands to implement these efforts— mass media campaigns, a telephone hotline, and personal communication through intermediaries.

The media campaigns feature every day situations, including interpersonal relationships, sexual situations, holiday travel, and leisure time, and disseminated messages through TV and cinema spots, advertisements, and posters. In-depth information is provided to German residents through leaflets, brochures, films, and documentaries.



Television public education campaign in Germany featuring everyday situations.

The telephone hotline, in nationwide operation since 1987, provides anonymous, personal counseling by trained staff. All media campaigns feature the hotline number and may generate many of the 2,000 to 3,000 calls received each month. When warranted, counselors refer callers for direct (face-to-face) counseling.¹² 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.

The Germans also have developed a few nontraditional and unique strategies. Research disclosed that girls and young women were getting significantly more information at home and at school about sexuality than were boys and young men. Because males generally preferred media, FCHE created a sexuality education CD, targeted to adolescent males through school libraries, youth programs, and the Internet. Traveling theaters and the "love bus," a van staffed by youth workers that provides information and condoms at beaches, rock concerts, and other gatherings of youth throughout the country, are two additional German strategies.

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.¹²

While these campaigns demonstrated increased condom use in the German population, some researchers worry that some social groups had been bypassed by both the campaigns and the evaluation. These researchers believe that those with disabilities, low reading skills, and mental illnesses need targeted attention.¹³ German health experts also worry about maintaining these condom use levels. At the start of the HIV/AIDS epidemic, the German government provided 30 million dollars (U.S.) for media campaigns each year; this sum has dwindled to eight million (U.S.). Also, public health experts worry that Germans are being lulled into a false sense of security because AIDS deaths are sharply down due to triple drug therapies. Recent studies show that fewer Germans are receiving

safer sex messages today than were 10 years ago, and some are receiving no safer sex messages. Social marketing experts believe it is only a matter of time before reductions in exposure to safer sex messages will result in more sexual risk taking among Germans.

Mass Media in France

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. More recent efforts also focus on preventing STDs.



Poster: CRIPS, Paris

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.¹⁴ The French programs also encouraged simultaneous dual method

use.¹⁵ The French campaigns have used posters, billboards, TV and radio commercials, special events, hotlines, pop and disco music, special products, and competitions to get their messages out.

CRIPS is an international repository of AIDS social marketing materials, including media materials used around the world to promote protective sexual behavior. CRIPS has consistently used a powerful marketing tool—involving the target group in producing the safer sex materials. More than any of the other countries studied, France encourages adolescents to produce the messages targeted to



"Love without Fear" poster, CRIPS, Paris

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.¹⁶

CRIPS also sponsored scenario contests, asking high school students to produce ideas for television and cinema spots. Using the best of these creative ideas, CRIPS staff recruited actors and actresses from widely known French soaps to produce ³¹ vignettes. The vignettes aired in schools, at cinemas, and on television. Another series for national television, *The Joy of Life*, depicted the grandmother in a multiracial family educating her grandchildren about sexuality. The 20 segments began with contraception and depicted accepting discussions on relationships, pleasure, and, of course, respect and responsibility.



Poster: CRIPS, Paris

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. One recently produced and successful project features AIDS prevention posters from around the world, set to energetic disco music. The video is distributed free to discos, bars, and clubs

and plays in repeated one-hour loops. The images create a sense of excitement and normalcy around condom use, promoting condoms as a natural part of sexual expression.

Media campaigns promoting protective behavior were more noticeable in Paris than in any other city on the tour. On the road that circles the city from north to south, condom billboards, up for World Cup soccer fans, were evident and understandable, even to those speaking little or no French. Tourist maps indicate

where condom machines are located as well as locations

for needle exchange and drug rehabilitation. Condoms are distributed and promoted among the international travelers who come to Paris for events such as the World Cup soccer games. Safer sex messages are displayed during events. While the French campaigns are less strategically planned than the Dutch or German campaigns, the campaigns are more focused toward youth and other groups at higher risk for HIV and STDs.



Poster produced for World Cup Soccer Games.



Special condom packaging for World Cup Soccer Games.

Conclusion

In the 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.

The nations that were studied utilize mass media as a partner to spread the public health message. In contrast, American mass media has almost become a burden to reducing the adverse consequences of sexual risk taking.

—Study Tour Participant

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 promoted a more open and frank discussion about sexuality than had existed before the campaigns. Dutch, German, and French experts believe such discussions contribute to the acceptance of sexuality as a normal and healthy component of life for everyone.

While the three European countries' mass media approaches are comparable, the differences are clear between the European and the United States' approach. Over the past 12 years, the Netherlands, Germany, and France have implemented longitudinal, explicit, multi-channelled campaigns directed toward the entire sexually active population, including adolescents. Each of the three European nations provided abundant evidence that their media campaigns are long-term, consistent, targeted, and effective. By comparison, in spite of having the highest HIV/AIDS rates in the western world, the United States has not provided long-term, consistent, and effective media campaigns targeting all sexually active residents.

In the years since the rise of the HIV/AIDS pandemic, the Netherlands, Germany and France have strategically planned and delivered mass media campaigns, based on research and social learning theory, to alter sexual health attitudes and behaviors. Dutch, German, and French campaigns were practical, targeting safer sexual behavior and aligning messages with research about the natural growth and development process of humans. While research also plays a role in the development of U.S. media campaigns, the products are often diluted or dismantled by political and ideological opponents. While the campaigns in the three European nations were funded by government, public health experts, artists, and members of the target audiences ran the projects and were trusted by their governments to create effective products.

Dutch, German, and French mass media campaigns extended the messages through intermediaries such as youth and social services workers, counselors, teachers, pharmacists, and physicians who repeated the messages in face-to-face situations with young people. Each European nation has hotlines staffed especially for youth. The Netherlands and France have safe sex holiday campaigns. The Netherlands and France view major events, like the World Cup, as special opportunities for impacting sexual behavior. These events are seldom used to disseminate safer sex messages in the United States.

Teens in the United States report needing medically accurate and realistic information which recognizes that their sexual nature is normal and positive and acknowledges their freedom to choose when and how to express it.¹⁷ In contrast, what teens in the United States currently get are mixed messages, simultaneously encouraging them to have unprotected sex and to have no sex until they are married.

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 do not include messages that blame an infected person for transmitting infection. 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.

Media campaigns in the Netherlands, France, and Germany demonstrate their clear commitment to reinforcing safer sex messages over time, in recognition that new cohorts of youth need to see and hear the same messages that early cohorts have internalized. Finally, the range of attention given to sexuality issues in these three nations and the openness with which they are presented is one of the most profound and remarkable observations made on the tour.

All of the campaigns had one important feature: If you are going to be involved with someone sexually, you are allowed and expected to act responsibly and use protection. Sexual activity is not condoned but using protection is.

—Study Tour Participant

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Chapter 3

Reproductive and Sexual Health Services for Youth

To understand the role that access to reproductive health services plays in the prevention of unintended pregnancy and STDs, including HIV, in the Netherlands, France, and Germany, participants gathered information on each country's adolescent health services. The study tour was particularly interested in the degree to which services were specifically tailored to meet the needs of adolescents—that is, how “teen friendly” they were—and the training of health care professionals and staff to make services “teen friendly.” Finally, participants wanted to know whether reproductive and sexual health services for adolescents focused on the positive or on preventing negative consequences and whether the services focused on sexual health as a multidimensional aspect of the teen's entire life.

This section presents an overview of each country's health care system and gives special attention to the policies, laws, and specific actions that assist or deter teens in accessing reproductive health services.

Reproductive Health Care in the United States

The health care system in the United States is cumbersome and complex. Options for health coverage vary from state to state. Approximately 85 percent of U.S. residents have health care coverage through either public or private health insurance. Increasingly today, private coverage tends to be offered through health maintenance organizations or group plans provided by employers.¹ Insurance premiums may be shared in varying degrees between the employee and employer or, more rarely, fully paid by the employer. Members of some groups of people, such as the elderly, Native Americans living on reservations, or the poor may have health care provided through federal and state funded programs, such as Medicaid and Medicare.

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.¹ Young, unemployed, and uninsured people who lack financial resources may also have reduced access to effective contraception. In this context, it is useful to note that approximately 67 percent of teen pregnancies in the U.S. occur among 18- to 19-year-old women.²

Reproductive health care is among the services least likely to be covered in the U.S. health care system, particularly for teens. For instance, many adults' health insurance fails to cover a pregnancy in minor children. 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.³

In the United States, two public sources support sexuality related health care services: Medicaid and Title X. Although public health coverage is difficult to describe and varies from state to state, Medicaid provides health care to eligible low income families¹ and accounts for 58 percent of all federal family planning expenditures.⁴

Title X, the National Family Planning Program started in 1970, funds organizations that provide family planning services to improve maternal and infant health, lower the incidence of unintended pregnancy, reduce the incidence of abortion, and lower STD rates.⁵ Title X provides money to community agencies which deliver both educational and health care services, including gynecological exams, contraception, pregnancy testing, sterilization, natural family planning, and screening for STDs and cervical and breast cancers. Abortion services may not be reimbursed by Title X funds. Title X serves approximately five million women each year. Of those, 85 percent are from low income families, 30 percent are adolescents, and 60 percent are younger than 25.⁵ Experts recently estimated that Title X funding annually averts an estimated 386,000 adolescent pregnancies in the United States.⁵

Teens have access to reproductive health services through private organizations and school-based services as well. Planned Parenthood Federation of America affiliates provide education and reproductive health services but target 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.⁶

In 1973, the Supreme Court decision *Roe v. Wade* made abortion legal throughout the United States, allowing women to choose during the first trimester the outcome of their pregnancies. States regulate second trimester abortions, and

third trimester abortions are illegal except when the life of the mother is endangered.⁷ States impose a variety of laws to reduce the demand for abortion, including mandatory waiting periods and parental consent requirements. In some states, clinicians must tell women seeking abortion about its potential negative consequences, although they need not mention the consequences of other options. Most states deny public funds for abortion. One deterrent to abortion in the United States is violence directed at abortion providers and harassment of women seeking abortion. Protest is legal in the United States and is protected by the Constitution. However, illegal, violent acts—bombings and assassinations—may deter some pregnant women from seeking the services they want and to which they are entitled.

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. Recently, the Food and Drug Administration approved a pharmaceutical company’s packaging of emergency contraception for sale. Slightly more than 28 percent of U.S. teenagers have heard of emergency contraception.⁸ Many teens in the U.S. are unaware of and fail to seek appropriate reproductive health services in a timely manner. Table 7 shows how long U.S. teen women delay seeking prescription contraception after becoming sexually active. A pregnancy or STD often drives U.S. teens to seek reproductive health services.

**First Year Delays in Seeking Medical (Prescribed)
Contraception After Initiating Sex**
Women Ages 15 to 19 in the United States ³

Timing	Percentage Delaying Seeking Services
Before or within first month	12 percent
By 3 months	22 percent
By 6 months	28 percent
By 1 year	40 percent

** Note. Percentages do not add to 100 percent due to rounding. These percentages refer only to young women who seek prescription contraception within the first year after initiating sex.*

Table 7

While more teens report using condoms at first sexual intercourse (65 percent)⁹ than formerly, the trend is less strong among Latino and inner city youth.¹⁰ Condoms are less available and more costly in the United States than in many other countries. While pharmacies stock them, condoms are often kept behind counters or where pharmacists can watch them. When teens in one survey were asked to rate the difficulty of carrying out various tasks related to sexual health, over 90 percent rated buying a condom in the public as nearly impossible.¹¹

In the United States, policies and practices discourage teens from using reproductive and sexual health services. Sexually active teens in the United States must overcome barriers ranging from lack of transportation and shortage of funds to pelvic exams and adult censure or disapproval when they seek to obtain the services they need.

Reproductive Health Services for Teens in the Netherlands

In 1980, Evert Ketting referred to the Netherlands as the country that is closest to exemplifying the “perfect contraceptive population.”¹² Yet 20 years earlier, contraception was not readily available in the Netherlands and family planning was not openly discussed.¹³ Displaying and selling contraceptives were restricted, and the medical community accepted no role in family planning.¹⁴ However, in one decade, five major factors created a paradigm shift to what is known as the Dutch “controlled liberalization.”¹⁴

- The Netherlands moved from a predominantly agricultural society to an industrial society.
- Rapid economic growth led to the development of a welfare state with an extended social security and health care system.
- The influence of religious institutions on personal decisions and in shaping public policy declined.
- Educational levels increased in the entire population.
- Mass media, particularly television, was introduced on a large scale.

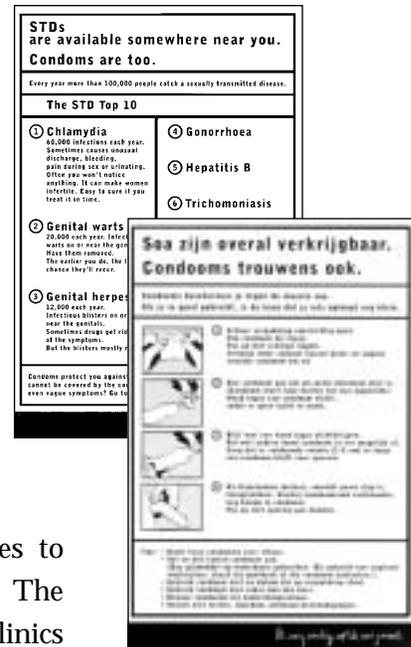
These influences supported a shift towards tolerance of consensual and responsible sexual expression. Since then, the Dutch have systematically reduced structural and interpersonal barriers to the practice of safer sex for all sexually active persons.

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 and reproductive care to the public and to provide sexuality education.



The Rutgers Foundation currently runs seven sexual and reproductive health centers¹⁵ 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. Rutgers' roles in the nations' sexual health has expanded, from dispensing contraceptives to providing education and counseling services as well as training and consulting within and outside the country. Currently, Rutgers serves clients that are hard to reach, especially single women, young women, and newly arriving immigrants.¹⁶

The Rutgers Foundation implemented a number of strategies to make services more welcoming and friendly to young people. The box below identifies the major principles which make Rutgers clinics easily accessible for adolescents. Rutgers locates facilities near schools or railway stations and the clinics remain open at hours good for teens. Small fees are charged because teens understand that “they must take responsibility for their sex life—sex is not free.”¹⁷ While the standard clinic fee is about eight dollars (U.S.), if a client cannot pay, she or he will not be turned away.



Teen Friendly Strategies Employed at Rutgers Clinics

- Accept teen sexuality and sexual behavior.
- Guarantee anonymity or confidentiality.
- Waive PAP smear and pelvic exams as prerequisites for contraception.
- Provide nonjudgmental service.
- Require minimal paperwork.
- Require no parental consent.

Unintended pregnancy is a relatively new concern for the Dutch when compared with efforts to control STDs. 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.¹⁸ 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. One clinic trains public health specialists from all over the world. See Figure 2 next page.

Amsterdam's Easy Access STD Clinic Trains Public Health Workers Worldwide

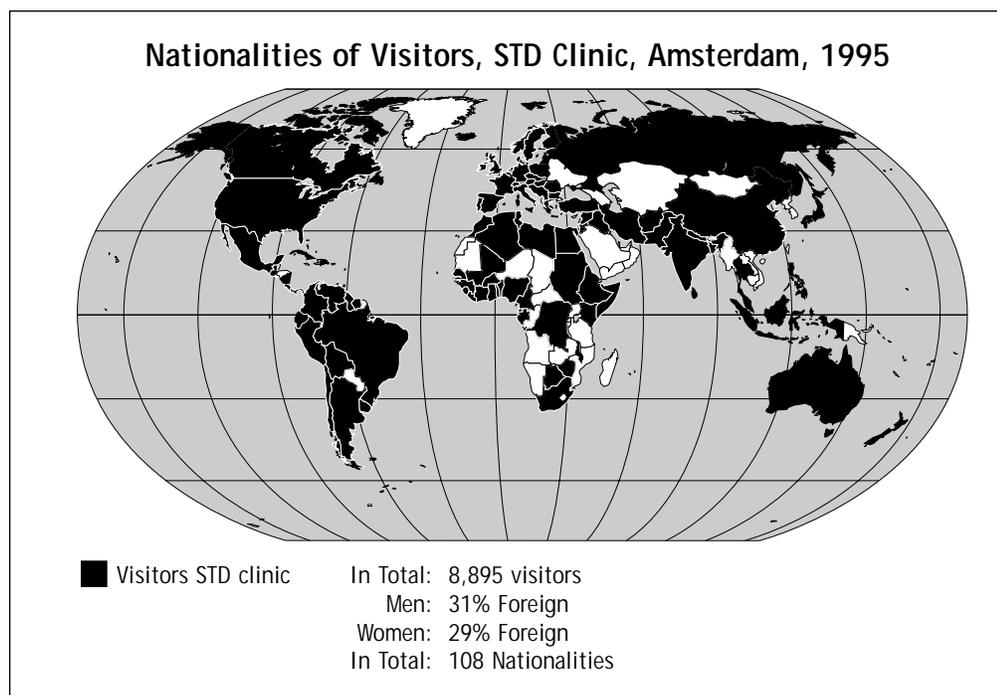


Figure 2

They don't have any forms for youth. They can walk in, and get a prescription for pills without double sided forms asking about grandparents' medical history. Talk about a barrier. And NO pelvic is required.

—Study Tour Participant

The clinics simplify paperwork by limiting questions to a few essentials, such as name, address, phone number and health card number, making the clinics easily accessible. The clinics are open 4.5 hours each day and operate 24-hour hotlines. Staff devote the remaining time to outreach.¹⁸ The doctors and nurses speak several languages and sometimes, to help clients understand the questions, use cue cards illustrated with comics. Translators are also available to provide assistance. Treatment is offered to everyone at no cost.

In 1997, staff at these easy access clinics made contact with 15,610 new clients. Nearly 27 percent of females clients were prostitutes and 27 percent of males were homosexual or bisexual. Three-fourths of the clients were Dutch born.¹⁸

While outreach groups play roles with young people and hard to reach clients, most Dutch youth see their family doctor for all health care, including sexual health. Since the 1960s, family practice physicians have energetically developed communication skills and mutual trust with Dutch adolescents. Family physicians receive regular training to improve communication with young patients and see the sexual health of young people as a major responsibility.

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.¹⁹ In addition, a separate compulsory social insurance plan covers all households.²⁰

Although the Dutch were one of the last western countries to legalize abortion, abortion rates in the Netherlands are the lowest in the world. While abortion, like other medical procedures, is paid for by the national insurance plan, women rarely request it.²⁰ Recent efforts to impose a charge for abortions, however, met with such fierce resistance that the government withdrew the proposal. Abortion in the Netherlands requires a five-day waiting period.

The easy availability of reproductive health services in the Netherlands contributes to the sexual health of Dutch youth. 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 clinic had a condom vending machine out front and a prominent sign declaring access and availability of emergency contraception.

—Study Tour Participant

Contraception is looked at as an abortion prevention method.

—Dutch Health Provider

Reproductive Health Services in Germany

The German government regulates the insurance market, and 90 percent of households have compulsory health insurance. Private insurance is available for the remaining ten percent of households with very high incomes. Although Germany has for-profit hospitals, most health care is delivered by physicians employed in non-profit or municipal hospitals.²¹ 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. Most Germans believe that sexual expression is a basic need and a normal, healthy part of personality development. Germans believe that sexuality is not to be feared but 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.²² Adolescents need not visit a physician to get contraception.²³ Germans view contraceptive

use as indispensable to sexual intercourse,²² and many German adolescents effectively use contraceptive methods. Among Germans, the pill is the most popular method of contraception, with 99 percent of family planning clients favoring it over other methods.²³ Some 63 percent of German teens use oral contraceptives and 57 percent use condoms.²³ Condoms are widely available in pharmacies, grocery stores, restaurants, clubs, and in vending machines in most public toilets.

Several studies show an increase in contraceptive use among German adolescents. In 1980, 22.5 percent were using no method. By 1994, 11.5 percent were using no method, a 50 percent decline.²⁴ According to a study completed by the Federal Center for Health Education (FCHE) in 1995, 79 percent of females and 69 percent of males reported that they were “always careful about avoiding pregnancy.” Only 16 percent of males and eight percent of females reported using no contraception at first sexual intercourse.²³ In general, Germans view contraceptive use as the way to avoid abortion.²⁵ 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.²⁶ Second trimester abortion is not permitted unless pregnancy endangers the mother’s life. Because German law is strict about second trimester abortions, German women travel to other countries for the procedure.²⁴ Abortion is also legal in cases of rape and incest and is covered by the national health plan. 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.²⁵ Women must seek counseling three days prior to the abortion procedure.²⁶

For convenience, women and teens often turn to local family planning clinics for reproductive health services. One of the most well known is ProFamilia. In an



Frau Katja Uhlis, ProFamilia, Dusseldorf

attempt to make access easier, ProFamilia clinics maintain a professionally diverse staff so clients do not have to be referred elsewhere. Sexuality education, counseling, and medical services are free and confidential as are all major methods of contraception. ProFamilia’s answering machines publicize emergency contraception by informing callers about when and how to use it and what to do if the office is closed.

Reproductive Health Services in France

The French health care system faces rising costs from an aging population and high technology medicine. Nevertheless, the country remains committed to national health insurance coverage, including freedom to choose among medical providers, for all French residents.^{27,28} About 99 percent of French residents are covered by health insurance.²⁹

The French health care system, *Securite Sociale* (SS), was created in 1945 and covers about 75 percent of health care providers' charges. Patients pay for services initially and are reimbursed for 70 percent of the charges by the SS and the remainder from insurance. SS covers 90 percent of charges for hospitalization; the remaining 10 percent is covered by private insurance; but in expensive illnesses, such as AIDS or cancer, medical care is free of charge.²⁹

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.²⁹ The age of consent is 15.

The main reason for providing low cost to no cost contraception 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. Women seeking abortions after the tenth week of gestation must go outside France. 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 women.²⁹ Demonstrations at reproductive health and abortion clinics are not permitted in France.

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. The government keeps condom prices low to make them affordable—about 20 cents (U.S.)³⁰ Some

France—All AIDS medications are FREE! No matter what, no matter who, you can even move to France and get the meds and care without having to really jump through hoops! What a concept—don't penalize people with AIDS through hideous costs for medication and treatments.

—Study Tour Participant

maps of Paris note the location of condom machines, needle drop boxes for used needles, and drug rehabilitation centers.



Study tour participants at MFPF.

France has many STD and family planning clinics. The Central Region for the Prevention of AIDS has eight centers in France, while the Mouvement Francais pour le Planning Familial (MFPF) has 66 clinics for education and services. MFPF provides educational programs in its clinics and on school campuses. Health departments run 1,053 Planification Centers and 259 centers which provide education, counseling, con-

doms 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.

Conclusion

All three European nations value sexuality as innately human and promote personal choice about sexual expression, for teenagers and adults. Principles of individual freedom in sexual expression are supported by the laws of each nation. 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, screenings, 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 United States, the value is not on safer sexual expression for adolescents but on sexual abstinence. Many barriers deter U.S. teens from accessing contraception, including transportation, high costs, pelvic exams, limited clinic hours, disapproval of adults, and fear that parents will find out. Negative messages about sexuality combine with significant barriers to health care services lead to sexual risk taking behaviors in the United States.

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Chapter 4

Sexuality Education

During the study tour, participants focused on gathering information that would help them understand sexuality education in the Netherlands, Germany, and France. Participants asked about formal sexuality education—its guidelines, teachers, content, and evaluation as well as the training of educators. Participants sought information on the focus of sexuality education, whether it was a positive sexual health model or oriented to disease and negative consequences. Participants sought to learn the extent to which parents and communities support sexuality education for young people, the role of government in setting national and local policies about the content of sexuality education, and the extent of opposition or controversy around sexuality education. Finally, participants were eager to learn about links to health services and public education campaigns.

Sexuality Education in the United States

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.¹ 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.² Most mandates for abstinence education came from state legislatures rather than from state departments of education.

What do you fear? What drives you to mistrust and withhold information from people?

—Public Health Official,
Germany

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.³ 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 1960s, the focus of sexuality education in the United States was on increasing knowledge about growth and development, reproductive anatomy, physiology, STDs, pregnancy, prenatal development, birth, and parenting in the belief that having accurate facts would reduce sexual risks in young people. In the 1970s, the focus shifted to developing effective skills, such as decision making, and to assisting students to clarify their values. In the 1980s, the Congress passed the Adolescent Family Life Act, which introduced and required chosen programs to teach only abstinence (*abstinence-only* education). 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, *accurate and balanced* sexuality education, encourages students to postpone sex until they are older and to practice safer sex when they become sexually active. Table 8 depicts major strands in U.S. sexuality education. 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.

**American Sexuality Education Strategies to
Reduce Sexual Risk: 1960-1998**

Decade	Focus	Description
1960s	Content based instruction	Knowledge, information, facts about sexuality
1970s	Affective based instruction	Values, values clarification, decision making
1980s	Abstinence instruction	"Just say no to sex"
1990s	1] Abstinence-until-marriage instruction	Virginity is the standard until marriage
	2] Accurate, balanced, instruction	Delay sexual intercourse until ready and then practice safe sex

Table 8

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.³

Our instructor said,
'Ask any question.
There is no shame.'
We could write
the questions down
so they were
anonymous, and the
teacher would answer
anything.

—Dutch Teen

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.² States' plans for using the money include community-based youth programs, school programs, and media campaigns.

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.⁴ 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.⁴ Some schools now limit their instruction to abstinence-until-marriage, often omitting lessons covering sexual intercourse, condoms, contraception, and protective sexual behavior.

The second U.S. approach, defined by proponents as accurate and balanced sexuality education, takes a wider 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.

Two additional external studies, from the World Health Organization and UNAIDS, have reviewed the research and evaluation 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 accurate and balanced 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.^{5, 6}

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 and balanced sexuality education in the schools, a belligerent minority threatens administrators with community controversy and negative media attention if sexuality education actually deals with sexuality.

I think it is vital
that we ditch the fear
and panic foundation
that we have in
talking about sex...

—Study Tour Participant

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.⁷ Support for teaching “controversial” topics is stronger than at any time since Gallup started doing this survey: 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.⁷

Even with this level of support from parents, government policy remains focused on abstinence from sexual activity. In the United States, parents demand sex education that will help young people understand how to protect themselves against HIV infection; yet, many teachers are forbidden to discuss behavior that poses high risks for HIV infection—unprotected sex with a partner at risk for HIV infection. Parents want teens to avoid pregnancy; but often teachers are prohibited from telling young people where to obtain contraception or how to use it correctly. Many teachers are convinced that a sizable number of students are having sex; but teachers are required to discuss abstinence with students rather than protective sexual behavior. In many schools, teachers are forbidden to discuss or display condoms and contraceptive devices, even with older teens or with pregnant and parenting students.⁸ Unfortunately, some sexuality education programs are so censored that youth call them “sexless” or “senseless” education.

Sexuality Education in The Netherlands

Education is a highly valued right in the Netherlands.⁹ 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.¹⁰ A child in the Netherlands can attend any public or private school at no cost, and the Dutch have the right to choose or establish a school on the basis of shared values.¹¹ Dutch schooling consists of primary education for eight years, followed by one of four types of secondary education.

Parents and the student choose which secondary experience the student should have. This choice is critical to the young person's future because the school type and student scores on state examinations determine his/her career options. The four types include: 1) pre-vocational training; 2) junior secondary education, which takes four years beyond primary school; 3) higher senior secondary school which takes five years and allows students to enter applied professions; and 4) pre-university which takes six years and focuses heavily on research and the sciences. These four tracks enable teachers to meet the sexuality education needs of students and tailor materials to their reading as well as to their intellectual, emotional and developmental levels.¹²

In the Netherlands, 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.¹² In 1993, the Netherlands added sexuality education questions to national exams. Currently, almost all secondary schools and approximately half of the primary schools address a wide range of sexuality related issues.¹³

The general philosophy of sexuality education in the Netherlands is not to teach but to talk about sex.¹⁴ Dutch teachers approach sexuality issues with their students, no matter what subject they teach, and sexuality education is integrated into many school courses, especially biology, health courses, and classes on social policy and religion. Education about sexuality starts with preschool children and is included in all levels of schooling.¹⁵ All teachers have complete freedom to teach anything the students want to learn about sexuality.¹³

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.¹⁶

Dutch educational leaders have developed an interactive sexuality education CD which simulates conversations with students and allows teachers to respond in a variety of ways. The CD presents student with questions or problems and offers alternative outcomes. The strategies remove the teacher from the front of the classroom to assume a facilitating role with students who direct their own learning through role playing, negotiation, and other interactive skills.⁹

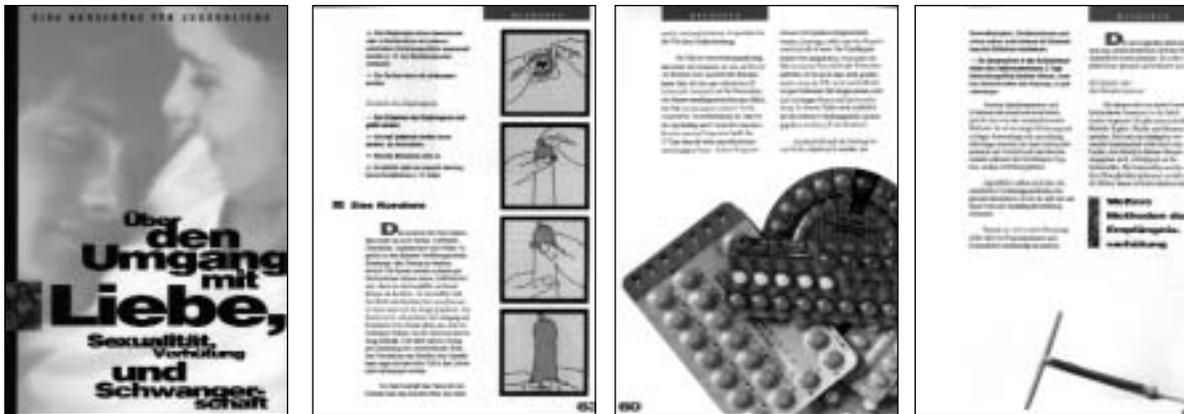
The Dutch view sex as a normal part of life for adolescents and adults. They accept teenage sexual behavior nonjudgmentally. Data demonstrate no lowering in the age of sexual initiation and few negative consequences, such as STDs and unintended pregnancies.¹⁴ The Dutch provide sexuality education in schools without censorship, religious backlash, or political fallout.

Sexuality Education in Germany

Although each of the 16 states in Germany operates its own educational system, in each state after elementary school, students are assigned to one of three secondary schools: realschule, hauptschule, or gymnasium. Realschule, for low academic performers, includes a work-study component. Hauptschule is for moderate academic achievers, and gymnasium, for the best academic students, is similar to college preparatory programs in the United States.¹⁷ Each school system tailors programs to the intellectual level of its students; the divisions make it easier to target sexuality education to the reading and developmental levels of students.

In Germany, sexuality education must be comprehensive and address the widest range of age and target groups.¹⁸ Germany has no national curriculum or special course on sexuality education.¹⁹ Teachers and principals have the freedom to conduct their programs in any manner they desire.¹⁷ Thus, the amount and quality of sexuality education provided depends on teachers taking the initiative and allowing time away from their regular subjects. Often, teachers will invite guest lecturers from community-based reproductive health organizations such as ProFamilia.²⁰

The German Federal Constitution Court Schools gave responsibility for sexuality education to schools, community-based organizations, and the highest health authorities.¹⁸ 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 preventative health care and avoiding or resolving conflicts in pregnancy; 2) disseminating



Excerpts from German Sexuality education text.

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.²⁰ 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.

The current, prevailing attitude toward sexuality education has evolved since World War II. Sex education of the 1950s had the goal of shielding young people and preserving their innocence and was designed to discourage adolescent sexual behavior by distracting teens or “arousing feelings of fear and disgust.”²¹ Teachers focused on the negative consequences of sexual expression, and society used repression, sublimation, surveillance, and punishment to enforce abstinence. In the 1960s, this approach was replaced by pseudo-affirmative sex education which was similar to the cognitive approach utilized in the United States at the same time. It aimed to eliminate fear through knowledge but at the same time to distract adolescents from sexual sensation and desire.²¹

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.²¹ 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.²¹ Table 9 briefly describes the major phases of sexuality education in Germany and the educational goals, principles, methods, and aims of each phase.



A German sexuality education board game.

German Sexuality Education: From Negative to Emancipatory²¹

Type of Education	Educational Goal	Principles and Methods	Understanding
Negative sex education	Preserve innocence as long as possible	Keep sexual expression away, distract, repress, sublimate, provide surveillance, and punish masturbation, STDs, premarital sex, and homosexuality	Learn about sexual awakening, that sex equals reproduction, about sexual danger
Pseudo-affirmative sex education	Increase knowledge of the body and ability to verbalize	Reduce fear, distract from genital expression, provide individualization	Gain a superficial recognition of sexuality as a human condition and be wary of premarital sex
Emancipatory sex education	Affirm cognitive, affective, and genital understanding and expression	Provide information and support, consider social conditions, teach conflict resolution, role playing, and self-experience	Understand that sexuality pervades the person's whole life from birth to death; experience sexuality through tenderness and desire; understand the genital and reproductive aspects but that they are not the sole function of sexuality; reduce fixation on genital or reproductive aspects of sexuality

Table 9

Table 10 displays topics currently addressed in German sexuality education. The concepts surrounding these main subject areas are similar to the conceptual framework recommended by the National Guidelines Task Force in the United States.²²



CD-ROM: Sexuality education, Germany

Germany's Goals for Sexuality Education²¹

Provides:

- 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

Motivates 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

Builds 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

Table 10

The computerized sexuality education component, *Love Line*, provides an example of new methods used in German teaching. Using *Love Line* students participate in discussions and interactions about sexuality, play interactive games, and access information. Because males exhibit higher sex education deficits than females, this technology was designed specifically to appeal to preferred male learning styles. Free modules also enable parents and teachers to work together.

The “Holistic Sex Education and AIDS Prevention” program resulted from a two-year pilot project in Schleswig-Holstein. Teachers, parents, students, sexuality educators, sexologists, drama teachers, and administrators worked together to design the teaching modules for classes and the accompanying pamphlets for the parents. The pamphlets provide information about the objectives and methods being used in the classrooms and suggest conversation starters for parents to stimulate discussion at home with their children. The program is interdisciplinary and designed for use in grades seven through 12 at all three levels of secondary education.

Sex Education in France

While most French children start pre-primary school at the age of three, school is required between the ages of six and 16. There are three levels of school, primary (ages six to 10), lower secondary (ages 11 to 15) and upper secondary (ages 16 to 18). Although upper secondary school is not required, 64 percent of students currently go on to this level.

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.²³

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.²⁴ 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 still remain taboo in French schools, and in Catholic schools, homosexuality and contraception to prevent pregnancy are unlikely to be discussed.

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.

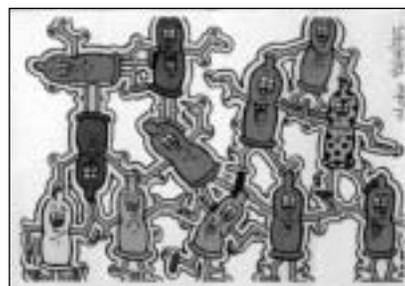


Poster: CRIPS, Paris

The MFPF and CRIPS provide free sexuality education, information and counseling for everyone—teens, teachers, community youth workers, and groups with special needs. Couple et Familia, grounded in feminism, gender equity, and human rights, assists schools in teaching values, such as responsibility, mutual respect, autonomy for saying no or yes, and community ownership of social issues. Couple et Familia works in school settings to decrease the barriers young people face in asking important

sexuality related questions.²⁵ The organization recently developed brochures to inform eight to 10-year-old students about aspects of sexuality they need to know, such as growth and development, reproduction, menstruation, and wet dreams.

In France, close ties exist among the 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.



Poster: CRIPS, Paris

Because sexuality education is nationally mandated, no French parent may withdraw a teenage student from the sexuality education program.²⁴ 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.

Conclusion

In the Netherlands, Germany, and France, sexual development in adolescents is 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. To protect sexual health, public campaigns coordinate with school sexuality education, condom and contraceptive access, and nonjudgmental attitudes from adults.

In the schools of these three nations, no 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.²⁶ The teaching is a collaborative effort among school personnel, community youth workers, reproductive health clinicians and volunteers.

In the United States, wide variations occur in sexuality education, ranging from mandates to exclusions, of particular sexual topics. Politics, not research, usually dictates the content of sexuality education programs. In some school districts, teachers are prohibited from discussing some topics—such as condoms, safer sex, homosexuality, and masturbation—while in some other school districts, teachers refrain from discussing the topics out of fear. Parents want sexuality education which will promote the health of young people, but conservative politics creates a sexuality education agenda that fails to provide youth with important personal and public health information.

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Chapter 5

Family, Community, and Religious Influences on Adolescent Sexuality

Study tour participants were keenly interested in gathering as much information as possible on the influence of family and community on adolescent sexuality—especially on values and behavior—in the Netherlands, Germany, and France. Participants were interested in learning about family acceptance of adolescent sexuality, about parental attitudes on adolescent contraception, and about parent-child communication on sexuality issues—how, when, and where communication occurs and what is discussed.

Finally, participants sought to learn about the role of religious institutions in shaping and transmitting values and beliefs about sexuality, reproduction, and family formation. Participants wanted to know whether religious institutions influence sexual health policies and programs in the Netherlands, Germany, and France.

Family and Community in the United States

Many adults in the United States believe that sexuality education should begin in the home. 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.”¹ 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.¹

In some families, youth receive the message while quite young that they should not ask questions about sexuality.² 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.³ Most teens who do have discussions about sexuality with a parent report having them with their mothers.^{2,3} Finally, 43 percent of teenage men and 65 percent of teenage women say they have no talks with their fathers about sexuality.² 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.³ 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.⁴

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.^{5,6} 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.⁶

Meanwhile, other studies among U.S. teens have found that students with the most parental support are five times less likely to be involved in risky behavior than those with the least support.⁷ Teen women with supportive families have an easier time accessing health services and less emotional stress associated with STD infection than do those with less supportive families.⁸ Teens who have talked with their mothers about contraception are three times more likely to use protection at first intercourse than are teens who have not talked with their mothers.⁹ Finally, while teens who have only had conversations with parents about abstinence are likely to initiate sex later than are teens who have talked about contraception with parents, they are also less likely to use contraception when they become sexually active.¹⁰

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.^{11,12,13}

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 Children's Aid Society has demonstrated delayed first intercourse, increased use of contraception, and reduced adolescent births.¹⁴ Two

community-based models that have shown promise include School/Community Sexual Risk Reduction,¹⁵ currently being replicated at several sites in Kansas, and the Plain Talk Initiatives,¹⁶ 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*, *Choosing the Best*, and *Teen AID*, focus on the dangers of sex and its negative consequences, as well as its supposed psychological and emotional risks.^{17,18} Despite inconclusive or negative findings from evaluations of such abstinence-only or abstinence-until-marriage programs¹¹, 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. Popular abstinence clubs, such as Best Friends and True Love Waits, ask youth to pledge not to have sex until they are married.

In the United States, parents and communities want youth to make healthy decisions about sex, 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.^{17,18,19,20} 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 uncertain as to the best means to promote adolescent sexual health.

Family and Community in the Netherlands

Several characteristics of Dutch society are important to consider in understanding the roles of family and community in adolescent sexuality. Until recently, the Netherlands had the lowest rate of working and economically independent mothers in the western world and more Dutch children lived in nuclear families compared to children in other developed nations.²¹ Secondly, the Dutch culture strongly values humanism, socialism, and liberalism—together encouraging tolerance for a wide range of opinions, attitudes, and lifestyles.²² Surprisingly, Dutch tolerance for philosophies and lifestyles different from their own is accompanied by a strict philosophy for living up to the standards of the individual's subgroup. While most residents of the Netherlands believe in “sticking to

the rules,” they are seldom evangelical and generally have little interest in imposing their standards on others, including their children.²³

Thirdly, the Dutch strongly value pragmatism and generally dislike discrepancies between their individual life philosophies and personal behavior.

They try to create an atmosphere of security for their children and teach them how to make decisions for themselves. Then they put a lot of trust and confidence in the decisions of their children.

—Parent Interview,
Maastricht

When their lifestyles change, the Dutch adjust their philosophies to match.²³ For example, after World War II, people could not afford large families while they and their communities recovered from the war’s devastation. The Dutch formed the Society for Sexual Reform, the Protestant Society for Responsible Family Planning, and the Catholic Bureau for Sexuality and Relations to influence and temper traditional church doctrines about contraception. When these efforts were unsuccessful with the Roman Catholic Church, Dutch Catholics began ignoring virtually all of their church’s teachings about sexuality. During this period, family planning law in the Netherlands was brought into line with society’s liberal trends as the Dutch used pragmatism to guide behavior and to affirm values.

Finally, the Netherlands strongly pursued socio-sexological research, beginning in the 1960s, with a focus that has evolved from restrictive sexuality to liberal sexuality, family planning education, and research on sexual abuse and STDs.²¹ Most studies, published exclusively in the Dutch language, had a strong impact on the sexual health knowledge and attitudes of the citizens. 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.^{23,24}

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. The pragmatic, individual ethic of most Dutch people means that parents and others provide support for young people, based on research showing that fostering communication and health relationship skills is key to reducing sexual risk among adolescents. Parents accept that their young people will probably become sexually active during their later teen years and openly discuss sexuality and sexual behavior with their children.^{24,27}



Two Dutch teens interviewed by Shelly Evans at Café Easy.

Reviewing the Dutch identification of the sexual phases of adolescent development (see Table 11) helps clarify parental tolerance. As the table illustrates, most adults in the Netherlands expect young people to progress from same sex 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.²⁸

Step-Wise Interaction Career²⁸ Sexual Phases of Adolescent Development

Phases	Ages	Description
Phase I	12 to 13	Generally, adolescents are concerned with changes occurring to their bodies and are not interested in sexual experimentation. They generally remain in peer friendship groups.
Phase II	14 to 15	Adolescents leave the safety of the same sex peer group. They focus on learning how to approach those outside the peer group, especially those to whom they are attracted. In this phase, adolescents usually experience their first sexual contact—hugging, kissing, and possibly fondling and petting.
Phase III	16 to 17	Adolescents begin having intimate relationships. Short-term relationships are characteristic of this experimental stage. Young people focus on practicing communication and relationship skills. About half of 17-year-olds experience outercourse and about half of those 17.8 years old experience intercourse.
Phase IV	18 to 19	Adolescents look for a committed relationship, signaling the end of experimentation and a focus instead on the emotions of a relationship.

Table 11

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.²⁸

In the Netherlands, most parents provide support from a distance and give teens permission to ask questions without incurring either judgment or consequences.²⁸ Few adults attempt to scare youth about sex. Instead, most adults focus on sexual choice and, therefore, give adolescents rights, respect, and responsibility.²⁷

Dutch students asked us why kids in the United States had access to guns but not information about sex. They commented about the violence we tolerated in our society.

—Teen Interview, Maastricht

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.²⁷

Communities invest heavily in adolescents through education, parental and community support, building skills in communication, and employment training. They also provide other opportunities for youth to feel strongly connected with adults and optimistic about their futures.

The Dutch view their young people as one of the Netherlands most valuable resources.

Study tour participants observed community comfort with and acceptance of sexuality as normal and healthy at an exhibition at a major museum. The exhibition featured over 60 posters and other materials on social issues produced by the clothing company, Benetton. Families strolled the galleries viewing the explicit sexual art, including photographs of the genitalia of many individuals. Parents helped small children find photographs of genitalia that resembled the children's and used the photographs to answer questions. Participants particularly noticed parents discussing the issues featured in the exhibition and, especially, how easily parents were able to talk about what they were seeing. In the museum, specially packaged Benetton condoms were available for purchase as were lesson plans for use in discussions on the social issues raised by the posters, including HIV/AIDS prevention, racism, sexism, peace, justice, and homophobia.



Concept: O. Toscani
Courtesy of United Colors
of Benetton

Adults of all ages cohabit in the Netherlands. Dutch culture values maintaining love and respect in a relationship much more than getting and staying married.²⁹ It is an ethic that values love, respect, tolerance, equity, and responsibility.²⁴

Family and Community in Germany

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. According to the Federal Center for Health Education (FCHE), Germans believe that sexuality is an existential need of humans and is central to human identity and personal development. To Germans, sexuality combines biological, psychosocial, and emotional elements and entails a range of positive and negative outcomes.³⁰

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.³¹ A recent survey indicates that parents consider sexuality education an important preventive measure.³²

A study in 1983 found that 50 percent of German parents *objected* to teens under age 18 having sex on general principles.³³ However, 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.³⁰

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.³²

The same study found that both parents and teens had some knowledge deficits about sexual matters. While 67 percent of teen women and 40 percent of teen men claimed to know the most favorable time for conception, only 57 percent of young women and 33 percent of young men correctly identified the most favorable time. Among their parents, 90 percent of mothers and 80 percent of fathers claimed to know the answer, but only 78 percent of mothers and 67 percent of fathers accurately answered the question.³² 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

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 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. Staffed by two social workers, the goals of the *Love Tour* include reducing barriers to sexual health services and disseminating sexuality education to youth.³⁴

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.³⁵ With family and community support, many German teens wait until they are ready to initiate sexual intercourse rather than feeling pressured to initiate sex, as some U.S. teens report.^{36,37}



Poster: CRIPS, Paris

Family and Community in France

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.³⁸ 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.³⁸ 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.³⁸

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 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.

Religion and Sexual Health Policies and Practices in the United States, the Netherlands, Germany, and France

Established religion plays an important role in the lives of residents of the United States, where religion is frequently considered important in transmitting values, including those related to sexuality, reproduction, and families.⁴⁰ More people in the United States regularly attend worship services than do in the Netherlands, Germany, or France; further, U.S. residents are also more likely to identify themselves as Christians and/or to profess a high degree of religiosity.^{41,42} Eighty percent of people in the United States marry and even more hold final

rites in religious settings.⁴¹ Most religious institutions in the United States transmit values through an alliance with families, usually via formal instruction or religious services.⁴⁰

The voice of the majority can speak so loudly at times that it drowns out any other voices from being heard. The voice of adolescents often depends on the voice of adults. The rights of adolescents to remain sexually healthy depends on the voice of adults that hold power.

—Study Tour Participant

Although religious institutions play an important role in transmitting values about sexuality and reproduction, they provide little guidance for adolescents about sexual development. Although some national religious institutions have developed their own sexuality education programs, few affiliates in communities use them to teach their youth groups.⁴³ When a national sample of 3,000 young people were asked how often their faith communities addressed various important issues, most responded that they remembered less than two hours spent discussing sexuality at church programs.⁴⁴

Many religious institutions in the United States have formal declarations addressing contraception, abortion, procreation, and marriage. While many—such as the Episcopal Church, the Jewish Reformed Congregation, and the Methodist Church—support contraception and the right of women to choose abortion, others—such as the Roman Catholic Church, the Church of the Latter Day Saints, and the Lubavitcher Hasidic Jewish sect—prohibit abortion and the use of contraception.⁴⁰ With regard to teen sexual behavior, conservative and fundamentalist churches are more likely than are more liberal churches to support traditional approaches, including abstinence-until-marriage and associating sex outside of marriage with sin and shame.⁴⁵ Liberal religious institutions are more likely to support sexuality education which focuses both on abstinence and on safer sex behaviors. However, regardless of the formal religious teachings of their faiths, individuals display a wide spectrum of sexual health attitudes and behaviors.⁴⁰

In the United States, the religious right—a political movement whose motive is to create public policy with a particular religious agenda—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 religious right, openly expressing its determination to influence political processes in the United States, has successfully placed supporters on school boards, county governing boards, and in state legislatures.

Religion plays a smaller role in contemporary European cultures of the Netherlands, France, and Germany than it does in the United States. Currently, about 40 percent of Dutch citizens acknowledge no religious affiliation or attend any religious services.⁴⁵ About 45 percent of Germans are Protestant, 35 percent Catholic, and 18 percent are unaffiliated. Further, 19 percent of Germans who

claim a religion provide it only nominal support.⁴⁶ While most of France's population is Roman Catholic, 22 percent claim another religious affiliation.⁴⁹ But, these statistics do not reveal the decline in all three nations in recent years in church attendance nor the diminishing belief in the importance of religious institutions for transmitting sexual values and beliefs.^{25,31,35,46,48}

The sexual revolution of the 1960s and 1970s also played a role in the declining influence of religious institutions. People saw that reproductive rights for women of all ages was central to their civil rights. Values began to shift away from a religious basis and toward an individual ethic supporting women's ability to be equal partners in relationships and their ability to participate in the work force. Laws were enacted that protected women's reproductive rights as a foundation of their civil rights. Study tour participants repeatedly heard that these reproductive rights, of course, extended to young women over the age of 15. Changes in family structure further challenged traditional teachings of religious institutions. With the declining role of organized religion, the family, schools, and media became important in transmitting values around sexuality.

According to social scientists and program planners in the three European nations, religious institutions recognize that their teachings must be consonant with changing social values and mores in order to be accepted as relevant. Thus, while religious institutions in the Netherlands, Germany, and France may not support a particular philosophy or practice, they accept that individuals may not abide by the dictates of the church. Then, too, many of the messages about sexual behavior, transmitted by schools and the media, are consistent with—or at least not in opposition to—traditional religious teachings. For example, in all three nations, messages promote responsible, consensual, and developmentally appropriate sexual activity.



Father De Jong, Student Chaplain, University of Maastricht and Jeanne Lindsay, study tour participant.

Individual freedom and responsibility in sexual behavior are important values to Dutch, German, and French people. In these countries, the morality of sexual behavior is weighed through an individual ethic that includes the values of responsibility, love, respect, tolerance, and equity. Morality is not the result of collective force, such as religious dogma. The values that are incorporated into the individual ethic align well with the ethical teachings of Christianity and Judaism.

Overall, major religious institutions in the three European nations do not seek to control public health policy or to stifle research based programs. Many of the

religious institutions of these three nations instead either maintain neutrality or quietly support programs and policies which improve the sexual health of the populations, including adolescents. For example, advertising condoms to prevent HIV infection is prevalent in France. Catholic bishops there have publicly advocated for the use of condoms to prevent HIV infection.⁴⁹

Conclusion

Wide differences in sexual attitudes and practices of families and communities occur among the United States, the Netherlands, Germany, and France. 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 expect young people to develop a healthy sexuality, supporting 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.

In the United States, most families and communities work to assist young people to make healthy decisions about sex. Strategies for doing so vary. In some

The importance of the Catholic leadership publicly advocating for the use of condoms in the prevention of HIV/AIDS should not be underestimated. This can have a direct effect on lifting barriers for young people concerning their sexual health.

—Study Tour Participant

communities, teens are supported with information and services related to sexuality. In others, it is believed that teens should not be sexual beings, and the adults believe that information about sex will lead to sexual behavior and work diligently to prevent teens from acquiring accurate and comprehensive sexual health knowledge. Some, seeking to prevent teens from initiating sexual intercourse, attempt to discourage young people from becoming involved in steady relationships. Many parents do not provide their children with as much honest, open communication regarding sexuality as young people say they 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.

A fundamental difference between the United States and the three European countries emerges in how teen sexual behavior is defined. This difference profoundly affects how families and communities 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 demands that all adults have a role in communicating 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 issue. These multiple perspectives create a confusion of efforts at all levels and provide a backdrop for competing and conflicting messages to teenagers.

In the European nations, public policy about sexuality and sexual health is more often dictated by pragmatism and research than it is in the United States, where a history of puritanism underpins conflicting attitudes about sexuality and often derails research-based public policy.

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Chapter 6

The Lessons Learned: Summing It Up and Call to Action

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 attitudes 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 respect 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.

Appendix

Personal Reflections on the Study Tour

by **Maureen Kelly, Participant**

You'd think a two week trip in Europe would yield stories of great coffee and wine and picturesque walks through ancient towns and beautiful churches. My stories do involve rambling about such things, but the real story is a little different. In six cities during two weeks this summer, I set out to learn about European approaches to adolescent sexual behavior and responsibility. From site visits and lectures to panel discussions with health educators, AIDS activists, general practitioners, and priests, I have come back to Ithaca, New York, with a newfound excitement for the real and positive impact of access to sexuality education, information, and medical services.

I learned that the U.S. teen birth rate and abortion rates are far higher than those in Germany, the Netherlands, or France. European teens begin having sex more than one year *later* than American teens, and European teens also have no more sexual partners during their teen years than do American teens. This means that getting frequent, accurate, positive, and accessible information about sex does *not* simply encourage young people to have more sex. The reality is that teens in the countries studied have sex as much as teens in the United States, without as many negative consequences. But they do get something our teens don't. They get inundated with positive, accessible information aimed at helping to prevent pregnancies, not just to prevent sex.

One of the key factors in the success of these European countries is that they have found a common ground among both traditional and non-traditional supporters of health and sexuality education. We need to learn how to work together to prevent pregnancies rather than working against each other to prevent teens having sex.

I was struck by the success of the sex education campaign in the Netherlands, supported and encouraged by such a broad array of people with an equally broad array of beliefs and values. Organized religious groups did not offer opposition to sexuality education but rather supported efforts to prevent unwanted pregnancies. We must take note of the successful outcomes of this non-adversarial relationship between religious communities and advocates for sexuality education and encourage each group to make strides toward that middle ground.

The positive, omnipresence of the media in the Netherlands, France, and Germany is an eye opening reality. In the U.S., we plan whole conferences on

how to teach kids to be media savvy consumers, but where are our efforts to present a new set of images and messages rather than focusing so much of our energy on damage control? This seems to be a common theme among American approaches to sexuality education. We have become quite skilled at responding to the negative outcomes of sex. We have some wonderful programs for pregnant and parenting teens. We have mentoring programs, tutors, and after school groups that tackle the tough reality facing teens today. But, I ask, where are our proactive efforts to create a new social norm about sexuality? Unfortunately, our efforts are spent reacting to the current social norm that is so inadequate that all our time, energy, and Band-Aids won't fix it!

All three of the countries visited during the European Study Tour have one major thing in common that, for me, plants a seed of hope. The positive and inclusive, nationally funded, sexuality education initiatives have all come about relatively recently. These nations have not always been how they are today. The Dutch, French, and German people did something that seems radical from the American perspective. They saw a problem, got unbiased, nonmoralizing, factual information about how to fix it, and set out to do so. The most impressive thing is—it works.

All three of the nations studied have seen a remarkable decrease in their teen pregnancy, STD infection, and abortion rates. The single most important aspect in the changes seen by these countries is that their collaborative efforts were aimed at increasing the health of their people. They have, on a national level, implemented a harm reduction program at its best. They saw negative outcomes they wanted to prevent, and they worked to create educational materials and access to services to address those negative outcomes. They did not simply attempt to prevent behavior. Their successes of these nations have been realized in a relatively short period of time.

I believe we have a staggering amount of work before us, but we also have at least three templates—Dutch, French, and German—from which to start. American success will depend on our ability to coordinate our efforts on the local level with a national movement. There are two equally important pieces of work that must be done; but they need to be done by different people, with different skill sets in different place, and they must be coordinated! As a sexuality educator in upstate New York, my energies must be focused on my community. I must work to build alliances, secure funding, support other educators, and be a part of the local movement to bring positive, health-based, sexuality education to my community. I visualize a national dot-to-dot puzzle that can only be completed by individuals in communities working with the guidance and support of national advocacy programs. People working locally must support and be supported by people at the state and national levels who are working toward the same clear and consistent goal.

I suggest that our goal is simply to increase the health of the American people. We can proceed from that goal to create action steps, but we must work together in our efforts to reach the goal. The motivation for our work must be based on facts, not on beliefs.

A portion of an interview of Bill Beckley with Louise Bourgeois appeared in the September, 1998, *Harper's Magazine*. Better than I can say, the exchange best sums up the contrasting social norms between European countries and the United States.

Bill: You were born in France, but you have lived a long time in the United States. What is the difference between the aesthetics of the two countries?

Louise: I'll tell you a story about my mother. When I was a little girl, growing up in France, my mother worked sewing tapestries. Some of the tapestries were exported to America. The only problem was that many of the images on the tapestries were of naked people. My mother's job was to cut out the—what do you call it?

Bill: The genitals?

Louise: Yes, the genitals of the men and the women, and replace these parts with pictures of flowers so they could be sold to Americans. My mother saved all the pictures of the genitals over the years, and, one day, she sewed them together as a quilt, and she gave the quilt to me. That's the difference between French and American aesthetics.

All three of the countries visited by the European Study Tour have seen dramatic changes in their adolescent birth, abortion, and STD rates as a result of their work over the past decade. We have a lot of work ahead of us, but we can be assured that if we play our cards right, it will pay off.