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SEXUALITY EDUCATION 1990

A Review of State Sexuality and AIDS Education Curricula

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Over the last two years, SIECUS has welcomed the dramatic increase in the number of states mandating and/or encouraging sexuality education and AIDS (acquired immunodeficiency syndrome) education. Less than three years ago, only three states, Maryland, New Jersey, and Kansas, plus the District of Columbia, had mandated sexuality education. As of November 1, 1989, 23 states now require sexuality education and 33 states require AIDS education; 23 have recommendations for sexuality education and 17 have recommendations for AIDS education.[1] It is even more encouraging that many states have expanded their legislative policies to include curricula and/or curricular guidelines;[2] 31 states have curricula for sexuality education and 42 states have curricula for AIDS education. The accompanying chart (see page 7) provides a breakdown of mandates and recommendations for each state, and indicates whether sexuality education and AIDS education curricula are produced by each state.[3]

While the number of mandates and recommendations are encouraging, there are great inconsistencies in program objectives, provisions for teacher training, program design, and course implementation and evaluation. Also, the mandates and recommendations often have caveats and restrictions that seriously call into question the usefulness of the program: there is an absence of provisions for mandate enforcement; lax restrictions regarding compliance that allow single school assemblies to constitute conformity; restrictive stipulations regarding curricula content that dilute areas of family planning and practices for HIV (human immunodeficiency virus) prevention; and a limitation of grade level implementation to the upper grades only.

The Alan Guttmacher Institute and the National Association of State Boards of Education have addressed these issues in their excellent studies of state policies of sexuality education and AIDS education.[4] Their studies point to the need to look at whether mandates/recommendations can be equated with the implementation of comprehensive and effective educational programs on a local level. Only minimal attention has been paid to the "quality" and "extent" of the sexuality information that has been provided as part of the sexuality education and AIDS education programs that have been mandated or recommended by the states.

The SIECUS Curricula Review Project

In 1988, SIECUS initiated a project to look beyond the mandate/recommendation numbers at sexuality education and AIDS education curricula and to review their *sexuality content.* The intent of the project was to assess, according to select criteria, the human sexuality topics that have been included in these curricula as part of the content areas and as part of the program objectives that outline student knowledge and skills.

The overriding question that prompted the curricula review was whether or not the increase in state mandates and recommendations had been paralleled by an increase in *comprehensive programs* — programs that provide thorough and relevant, quality sexuality information on a wide range of topics. More specifically, a decision was made to assess the sexuality topics that had been included in the curricula and in the curricular guidelines in compliance with state mandates; whether the information about human sexuality was thorough, up-to-date, and accurate; and whether the expressed view of sexuality was accepting and natural or prohibitive and judgmental. In the guidelines for AIDS education, the accuracy of the information on the sexual transmission of HIV was assessed and to what extent the pre-

ventive information included a thorough presentation of safer sex practices and condom use.

Methodology

In 1988, and again in May 1989, SIECUS wrote to the chief state school officers of all 50 states, and the District of Columbia, requesting information on any and all of their laws, rules, regulations, mandates or proposals concerning sexuality education and AIDS education. SIECUS also requested copies of the curricula and/or curricular guidelines in distribution at the time for each of the above. A review was then conducted of all the curricula and curricular guidelines received.[5]

Curricula and/or curricular guidelines on sexuality education from the following 23 states were received and reviewed: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Minnesota, Montana, Nevada, New Jersey, New York, North Carolina, North Dakota, Oregon, Tennessee, Texas, Virginia, and West Virginia.

Curricula and/or curricular guidelines on AIDS education from the following 34 states were received and reviewed: Alabama, Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, and Wisconsin.

Sexuality Topics and Evaluation Criteria

Historically, sexuality topics have been subsumed under various aspects of health education. Typically, such a framework has a biological and psychological focus that covers the general topics of: family relations; gender identity/roles/socialization; dating and marriage; reproduction, pregnancy, and childbirth; parenthood; growth and development; family planning; sexual values; attitudes and behaviors; and rape and sexual abuse. Comprehensive sexuality education and family life education programs often extend the range of subject matter to include the historical, ethical, and cultural aspects of human sexuality, human sexual behaviors, and sexual functioning.

SIECUS believes that the general objectives of sexuality education should be to provide students with accurate, relevant information; to provide them with educational opportunities to explore their sexual values, behaviors, and attitudes; to increase their self-understanding and self-esteem; and to provide them with a foundation for acquiring decision-making and communication skills in preparation for responsible, adult sexual lives. In most educational programs, these objectives, unfortunately, are subsumed within a preventive focus that centers on reducing teenage pregnancy by encouraging self-restraint or by what some curricula call "self-management" of sexual needs.

SIECUS believes that the objectives of AIDS education should include the elimination of misinformation about HIV/AIDS; the postponement of premature sexual involvement; the reduction of experimentation with drugs; the encouragement of increased condom use; and the encouragement of compassion for people with HIV/AIDS through effective education methodologies.[6] In actuality, the goals of most school-based AIDS education programs center primarily on the prevention of drug use and on emphasizing abstinence from all sexual behaviors, and exclude other preventive practices.

Sexuality Education Curricula and Curricular Guideline Review

The Criteria for Evaluation

Six select criteria were used in reviewing the sexuality education curricula and curricular guidelines received and as the qualifying features of what a comprehensive

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and thorough sexuality education curricula should include:

1. The overall accuracy of the information.
2. A discussion of changing family structures.
3. A presentation of new reproductive technologies.
4. An affirmation of sexuality as a natural part of human life.
5. A presentation of the variety and range of human sexual behaviors.
6. The inclusion of comprehensive family planning information.

Comprehensive and thorough curricula must contain current and up-to-date information. In the review of curricula this was determined by the date of publication and the overall inclusion in the material of current facts, statistics, and research findings. The most recent demographics on the average American family indicate that there has been a substantial decrease in the number of traditional "nuclear" families. An acknowledgement of this decrease necessitates changes in curricula. Also, divorce, unemployment, separation, and death have become familiar issues and topics of discussion for today's students. Acceptance and discussion of family changes and of different family structures now constitute an important part of an up-to-date sexuality education curriculum.

In addition, there has been a proliferation of new reproductive technologies that are now being used for the diagnostic purposes of determining fertility and infertility, prenatal conditions, and deformities; for surgical procedures during childbirth; and in the natural preparation of childbirth. The inclusion of these new technologies in the curricula also indicates whether the curricula are relevant and up-to-date.

A primary tenet of all sexuality education is the philosophical view that human sexuality is an important and natural part of a healthy life over the entire lifespan. A secondary philosophical tenet is an acknowledgement of diverse sexual behaviors, lifestyles, and experiences, with an emphasis on pleasure and satisfaction. If the curricula is in concordance with these views, it indicates that a positive, accepting approach to human sexuality is evident, and it denotes an acceptance of sexual pleasure as a legitimate topic of information and discussion for youth.

A comprehensive sexuality curriculum should include a family planning component that provides in-depth information regarding each contraceptive method, and should explain how it is used, the risks involved, its effectiveness, and its availability.

The Results

The publication dates of the sexuality education curricula material received indicated that five of the curricula were published between 1988 and 1989; six between 1986 and 1987; four between 1983 and 1985; three between 1980 and 1981; and five had no date at all. In other words, seven, or 30%, of the states were using curricula published prior to 1985 (Alabama, Connecticut, Georgia, Minnesota, New Jersey, North Carolina, and Tennessee); 11, or 47%, were using curricula published after 1985.

The overall findings are presented below.

Sexuality Education Curricula: An Overview of the Findings

(N = 23)

Overall Accuracy

Adequate	5	22%
Inadequate	2	9%
NA* (guides)	16	70%

Changing Family Structures

Positive	13	57%
Negative	1	4%
NA	9	39%

Sexuality as Natural Part of Human Life

Yes	15	65%
No	1	4%
NA	7	30%

Variety of Sexual Activities/Behaviors

Yes	2	8%
No	15	65%
NA	6	26%

Reproductive Technologies

Yes	4	17%
No	14	61%
NA	5	22%

Family Planning

Adequate	11	48%
Inadequate	11	48%
NA	1	4%

**NA, "not assessed" for this criteria, indicates that not enough information was provided to determine the appropriate category for this criteria. Most of the curricular guides that provide brief outlines of topic material fall into this category.*

Commentary

Overall, two general findings emerged from this review: most of the sexuality education curricula did not focus specifically on human sexuality as an area of study and exploration and a large percentage of the guidelines were out-of-date, particularly those on AIDS education.

The majority of the sexuality education curricula reviewed included the objective of "adequately preparing the student for adult relationships and parenthood," yet almost none highlighted human sexuality in and of itself as a primary and integral part of such preparation. While the areas of family relations, dating, growth and development were adequately covered, the human sexuality dimension was typically restricted to discussions of genital functioning and human reproduction followed by the traditional sequence of dating, marriage, and pregnancy. What was particularly and glaringly absent were the psychosexual dimensions of human sexuality that are essential for sufficient preparation for adult sexual life. Little, if any, attention was paid to such topics as gender identification, gender roles, and what it means to be a man or a woman in our society, to sexual values and ethical considerations of sexual behaviors, or to sexual functioning and gratification.

In reviewing the curricula, a clear distinction could be made between a sexuality education curriculum intended to be integrated within an existing health education program and a curriculum that could stand alone as an autonomous comprehensive course, such as family life education. When the sexuality curriculum was made part of health education, minimal information was generally provided, little specifics were included, and content areas were addressed using general, neutral terms, almost as if the concern was to not offend the teachers' and students' sensibilities. This was particularly true with the subject of family planning. When the sexuality curriculum was autonomous, it consistently was more thorough in its approach, included extensive discussions and explicit descriptions, and used exact terminology.

On the subject of the currency of the curricula, it is discouraging to note that almost one-third of the states are using curricula published prior to 1984 — even when one takes into consideration the lag time between publication and distribution. When the criterion of whether the curriculum included up-to-date information on reproductive technologies was addressed, it was found that, whereas practically all the curricula included information on pregnancy and the birthing process, few addressed the new, advanced technologies in these areas, i.e, fetal tests, childbirth procedures, etc. Most of the information was limited to an emphasis on healthy diets for pregnant women, newborn care, and the basics of child development.

In terms of the changing family structure, the majority of the comprehensive health curricula positively addressed this subject and emphasized the legitimacy of single-parent families and/or empathized with the traumas and difficulties experienced by many modern American families. Only the Alabama curriculum expressed a negative view of the changing family by making a distinction between "acceptable and generally unacceptable marriages." However, the large number of curricular guidelines that provided no information on this subject (39%) is cause for concern. No information on the changing family structure, for example, was provided by the Alaska, Arkansas, Iowa, Kansas, New York, North Carolina, Oregon, Texas, and West Virginia curricula.

On the positive side, the majority of the curricula did note, in a single statement, the natural and positive function of human sexuality, but unfortunately such a single statement was as far as most were able to go. Few provided any information on the historical and cultural aspects of human sexuality, on the range and diversity of sexual behaviors, or on sexual arousal and functioning. In fact, a number of curricula coupled their positive definition of sexuality, as a natural human drive, with the mandate that natural it is, but held in check it should be.

Examples of this orientation were found in the Connecticut curriculum, which encouraged students to understand the "value of self-control and postponing the gratification of sexual impulses"; in Georgia's curriculum, which emphasized "self-management"; in Kansas' and New Jersey's curricula, which stressed the appropriate expression and control of the sex drive;[7] and in New York's and Nevada's curricula, which emphasized the negative outcomes of sexual behavior to the exclusion of any other discussion about sexuality.

A disappointing aspect of the review was the almost equal ratio of inadequate to adequate curricula in regard to the criteria used for family planning information. To qualify for an "adequate" mark, the curricula needed to describe each contraceptive method and to provide information about its use, the risks involved, its effectiveness, and its availability. Only one-half of the curricula provided thorough information on family planning. In fact, many of the curricula either addressed family planning strictly as a problem that faces the entire universe — as in population control — or jumped directly from human reproduction to prenatal care, with little information on the "intermediate" step of conception and birth control. As mentioned earlier, many of the curricula took the minimalist approach. They discussed the subject of family planning very briefly and made use of global, neutral terms. Examples of this orientation were found in the Nevada curriculum, which referred to contraception as important for "use in adult life"; in the North Carolina curriculum, which described human reproduction and puberty, but failed to identify the genitals; and in the Texas curriculum, which referred to the objectives of teaching family planning as allowing the student "[to learn the] myths and misconceptions about conception."

Lastly, two of the curricula were rated inadequate based on the criteria of overall accuracy (five were rated as adequate, and 16 were guidelines that did not provide enough information to be rated as either adequate or inadequate). Information was deemed inaccurate if it was out-of-date, sketchy, omitted essential facts and/or figures, or was misleading or illusive. While Alabama's curriculum stated that "students seek information about sexuality," it failed to provide such information; for example, it asserted that sexually transmitted diseases were transmitted by "direct personal contact" without mention-

ing any types of intimate behavior. Tennessee's curriculum provided no information on human reproduction until the secondary school level, and then it provided no information on family planning at all.

AIDS Education Curricula Review

The Criteria for Evaluation

In the review of AIDS education curricula, eight criteria were used.

1. Overall accuracy of information.
2. Coverage of abstinence as a preventive practice.
3. Coverage of safer sex as a preventive practice.
4. Description of condom use.
5. Definition and discussion of homosexuality.
6. Emphasis on risk behaviors vs. risk groups.
7. Presentation of sexuality as natural part of human life.
8. Presentation of the variety and range of human sexual behaviors.

The information included in the curricula also was evaluated on the basis of whether it was current and up-to-date in regard to the transmission and prevention of HIV infection. The last two select criteria, sexuality as a natural part of human life and the variety/range of human sexual behaviors, were utilized as a basis of comparison between the AIDS education curricula and the sexuality education curricula reviewed and for the purpose of determining the philosophical approach of the AIDS education curricula with respect to human sexuality. The other five features clearly distinguished the thorough and relevant AIDS education curricula from those deemed inadequate and out-of-date.

An AIDS education curriculum improves its likelihood of educational effectiveness if it is up-to-date and accurate; provides information about various sexual behaviors and their relative risks as well as information on abstinence; contains material about safer sex practices for sexually active youth, including thorough information about condom use; and focuses on risk behaviors instead of risk groups. It is essential that factual information on HIV infection, transmission, and prevention be accurate and objective. Material that contained incomplete, misleading, or inaccurate information was rated "inadequate"; that which contained objective, thorough, and accurate information was rated "adequate."

The Results

The publication dates of the AIDS material indicate that 14, or 41%, were published between 1988 and 1989; 16, or 47%, between 1986 and 1987; and 4, or 12%, had no publication date.

The overall findings are presented below.

AIDS Education Curricula: An Overview of the Findings

(N = 34)

Overall Accuracy

Adequate	11	32%
Inadequate	15	44%
NA*	8	24%

Emphasis of Abstinence

Yes	29	85%
No	4	12%
NA	1	3%

Safer Sex

Yes	3	9%
No	20	59%
Basic	8	24%
NA	3	9%

Sexuality as Natural Part of Human Life

Yes	4	12%
No	19	56%
NA	11	32%

Information on Variety of Sexual Behaviors

Yes	9	26%
No	22	65%
NA	3	9%

Mentions Condom Use

Yes	25	74%
No	7	21%
NA	2	6%

Condom Information is Thorough

Of the 25 who mention condom use:

Yes	3	9%
No	22	65%

Homosexual Behaviors

No mention	12	35%
Refers to sexual orientation	7	21%
Refers to as risk group or "cause" of AIDS	13	38%

Risk Behavior Emphasis vs. Risk Groups

Yes	19	56%
No	13	38%
NA	2	6%

**NA, "not assessed" for this criteria, indicates that not enough information was provided to determine the appropriate category for this criteria. Most of the curricular guides that provide brief outlines of topic material fall into this category.*

Commentary

A clear distinction between the AIDS education curricula and the sexuality education curricula is the underlying urgency and alarm that is communicated in the former and is lacking in the latter. Faced with this deadly virus, the states are understandably concerned with protecting their students. The large number of states with mandates (33) and recommendations (17) for AIDS education, as compared to sexuality education (23 mandates and 23 recommendations), attests to this.

What is needed, however, is a comprehensive sexuality education or family life education curriculum with an extensive AIDS education component that contextualizes preventive information within a positive, life-affirming approach to human sexuality. Unfortunately, very few curricula place information about HIV infection and transmission within a positive context of human sexuality; most, in fact, gloss over the sexual transmission of HIV and focus on the development of "just say no" skills, with an emphasis on abstinence.

The Utah curriculum is uniquely explicit in its prohibitions to teachers about the context of AIDS education information and about its prohibitions against certain topics. For example, Utah's teachers are not free to discuss the "intracacies of intercourse, sexual stimulation, erotic behavior"; the acceptance of or advocacy of homosexuality as a desirable or acceptable sexual adjustment or lifestyle; the advocacy or encouragement of contraceptive methods or devices by unmarried minors; and the acceptance or advocacy of "free sex," promiscuity, or the so-called "new morality." This section of their curriculum is replete with warnings of legal violations for instructors crossing prohibition lines; their guidelines indicate that with parental consent, it is possible to discuss condom use at any grade level, but without it, such discussions are Class B misdemeanors. An interesting discussion is included, as to the teaching strategies that can be utilized to avoid penalties. Moreover, this curriculum warns students about the complicated, risky nature of sexuality, claiming that this fact is hidden by the simple view consistently offered by the media depicting "sex as a positive experience."

Even more alarming was the serious lack of accuracy, objectivity, and up-to-date information that was evident in the AIDS education curricula. More than one-half (59%) of the states are implementing AIDS education curricula that are almost three years old — a fact that is of great concern when one considers the amount of knowledge about HIV transmission and prevention that has been derived from research in the last two years. It is absolutely essential that factual information on HIV infection, transmission, and prevention be accurate and objective, yet almost one-half of the curricula were inadequate in this respect. Some specific examples will help to demonstrate this inadequacy. Hawaii's curriculum claims that there are no lesbians with HIV/AIDS; the Idaho curriculum warns against having sex with anyone who has swollen glands; and the Louisiana curriculum states that the high incidence of HIV/AIDS among Blacks is due to the fact that preventive information is not reaching them. Another example of inadequate information in the AIDS education curricula can be found in the Delaware curriculum that gender-stereotypes its students: boys are not shy about nudity, they have heard of intercourse, and they are involved in sexual play (there is no mention of girls at all); the genitals are defined as reproductive organs; the clitoris is omitted from the female diagram and the vagina is listed as a "birth canal," whereas the male penis is defined as the organ for urination and sexual expression. This curriculum also warns that "girls tire more easily than boys."

The subject of prevention was also carefully analyzed. The review focused on two primary methods: 1) abstaining from all sexual behaviors, either prior to the initiation of sexual relations or no longer being sexually active;[8] and 2) the incorporation of safer sex practices during sexual behavior, including the suggested use of a condom with nonoxynol-9, identification of and abstention from high-risk behaviors, and an emphasis on low-risk sexual behaviors and "outercourse," etc. A clear majority emphasized abstinence (85%), although some of these mentioned safer sex methods as well. The safer sex category, as depicted in the accompanying chart (see page 5), was further broken down between those that presented safer sex practices accurately and thoroughly (yes), those that clearly did not (no), and those that included minimal, incomplete information on safer sex (basic). This last category included curricula that used the word, "condom," or the phrase, "safer sex," but provided no explanations. The material was then evaluated as to whether or not condoms were specifically mentioned as a preventive measure. While 25 of the 34 (74%) did mention condoms as a preventive measure, only 3 (9%) did so thoroughly by discussing how to use a condom and by emphasizing its use with nonoxynol-9.

These findings are of particular concern. Educational programs cannot adequately protect their students from the spread of HIV if preventive information is limited to emphasizing abstinence at the expense of information about other preventive options. AIDS education programs must provide both sexually involved students, and those who *will be* sexually involved, with adequate skills for effective communication and sexual negotiation, as well as with accurate and thorough information about the range of risk behaviors and preventive practices from abstinence to outercourse to protected intercourse using dental dams and condoms with nonoxynol-9. The curricula of the following six states did a good job in this respect and provided AIDS education information accurately and nonjudgmentally: Michigan, Nevada, New Jersey, North Dakota, Minnesota, and Vermont.

The subject of thorough condom information is another matter, however. Information about condom use cannot be limited to the "word," but must explain how to communicate and negotiate with a partner and how to buy, use, and dispose of condoms. Not only did very few of the curricula provide this level of information, but many could be characterized as "preachy" and judgmental in their zealous stress on abstinence. AIDS education efforts might be more effective and more realistic if less attention was paid to rehearsing only the "just say

STATE UPDATE ON SEXUALITY EDUCATION AND AIDS EDUCATION

	MANDATES		*RECOMMENDATIONS*		*CURRICULA*	
	Sex. Educ.	*AIDS Educ.*	*Sex. Educ.*	*AIDS Educ.*	*Sex. Educ.*	*AIDS Educ.*
Alabama		•	•		•	•
Alaska			•	•	•	
Arizona				•		•
Arkansas	•	•			•	•
California			•	•	•	•
Colorado			•	•		•
Connecticut		•	•		•	•
Delaware	•	•			•	•
Dist. of Col.	•	•			•	•
Florida		•	•			•
Georgia	•	•			•	•
Hawaii	•	•			•	•
Idaho			•	•		•
Illinois	•	•			•	•
Indiana	•	•			•	•
Iowa	•	•			•	•
Kansas	•	•			•	•
Kentucky	•	•			•	•
Louisiana			•	•		•
Maine	•			•		
Maryland	•	•			•	•
Massachusetts				•		•
Michigan		•	•		•	•
Minnesota		•	•		•	•
Mississippi				•		•
Missouri			•	•	•	•
Montana			•	•	•	
Nebraska			•	•		•
Nevada	•	•			•	•
New Hampshire		•	•			
New Jersey	•			•	•	•
New Mexico	•	•				•
New York		•	•		•	•
North Carolina	•	•			•	•
North Dakota			•	•	•	•
Ohio		•	•			•
Oklahoma		•	•			•
Oregon	•	•			•	•
Pennsylvania		•	•			
Rhode Island	•	•			•	•
South Carolina	•			•		
South Dakota		•				•
Tennessee		•	•		•	
Texas			•	•	•	•
Utah	•	•				•
Vermont	•	•				•
Virginia	•	•			•	•
Washington		•	•			
West Virginia	•	•			•	•
Wisconsin			•	•	•	•
Wyoming						
TOTAL	23	33	23	17	31	42

State mandate is a requirement that all school districts provide sexuality education and/or AIDS education to their students, usually in the form of family life education programs or comprehensive health education. Mandates are usually accompanied by suggested curricula to be implemented at the local level.

Recommendations refer to any provisions by state legislatures or state departments of education that support sexuality education and/or AIDS education but do not require it. While curricula may be suggested, it is left up to the local districts to design and implement such programs.

no" approach and more to rehearsing discussions about sexual involvement, relationships, and skill building to negotiate the use of condoms.

In fact, a number of curricula provided sketchy, if any, information on safer sex, and at the same time counseled their sexually active students to *STOP ENGAGING NOW.* The curricula of Alabama, Connecticut, Kentucky, and Utah fell into this category. The New York curriculum includes a statement that its Board of Regents "view the use of condoms as extremely high risk behavior. The view that condoms should or can be used as a way to reduce the risk of transmission of AIDS should not be supported. The known failure rates for condoms present an unacceptable risk. Individuals who know the risk and persist in the use of condoms, should be strongly cautioned about the risks of condom failure." The North Carolina curriculum also focused on the risks of condom failure, and emphasized that condoms can and do fail, and that the infection rate among a sample of women using them is significant. Moreover, it stated that promoting condom use suggests to youth that adults expect them to be sexually active: "This danger must be borne in mind."

With regard to the philosophical framework of human sexuality, it is of utmost importance that material on HIV infection, transmission, and prevention be presented within the context of an accepting and positive view of human sexuality. As a life-threatening and sexually-transmitted disease, AIDS invokes great fear and anxiety, feelings that are often generalized to sexuality. A positive approach is particularly important for adolescents, who typically experience their share of stress during the profound changes of puberty.

In order to try to discern the sexual context in which AIDS education occurs, the curricula were evaluated as to whether or not they included an acknowledgement of sexuality as a natural part of human life and made mention of a range of sexual activities and behaviors. A dramatic difference between the sexuality education curricula and AIDS education curricula was evident in regard to the context of human sexuality — very few AIDS education curricula provided this positive framework, 12% vs. 65%. This unfortunate orientation could be characterized as a clear example of a problematic approach to human sexuality, with HIV/AIDS representing yet another of its negative consequences. On the subject of the range of sexual activities and behaviors, many more AIDS education curricula included this information, 26% vs. 8% of the sexuality education curricula. It appears that providing information regarding sexual behaviors and their relative risks was necessary in the discussion of HIV preventive practices, whereas, with the sexuality education curricula such information was more "expendable."

The last two criteria — the subject of homosexuality and high risk groups vs. behaviors — offer another important means of determining whether or not a curriculum provides objective, up-to-date, and accurate information. While homosexuals continue to represent the largest number of persons who are infected with HIV, education on HIV/AIDS information must distinguish this fact from an identification of homosexuals as a "risk group" or homosexual behavior as the "cause of AIDS." The AIDS education curricula were reviewed for their definition and discussion of homosexuality. Of those curricula reviewed, more than one-third presented a risk group analysis when discussing the transmission of HIV; more than one-third referred to homosexuals as a risk group or homosexuality as the "cause of AIDS"; and more than one-third did not mention homosexuality at all.

Within the last few years, a basic foundation of preventive AIDS education information is an emphasis on a range of *behaviors,* sexual and nonsexual, which vary from low to high risk of infection for those individuals engaging in them, regardless of their sexual orientation. This distinction is particularly essential to make in programs that target adolescents who characteristically disavow their potential HIV/AIDS risk with denial, projection (it's *those* other people of *those groups* that get AIDS, not me) and fantasies of invulnerability (it could not happen to me). AIDS education programs have an obligation to demonstrate to youth how it *could* happen to them and how young people can adequately protect themselves.

Some additional observations were gleaned from this review. Many of the curricula focused on providing advice to schools in regard to the legal, social, and medical implications of students with HIV/AIDS attending school. While it is important to include this information, many times it appeared that the need of school administrators and teachers to know how to deal with such situations overrode the need of students to have access to adequate information on preventing HIV transmission.

Many of the curricula provided very technical knowledge about HIV infection and transmission, and emphasized biomedical facts about the immune system, disease contraction, and prevention, at the expense of a frank, thorough discussion of preventive practices. The Louisiana curriculum is an example of this, as it included an extensive, complicated game for primary school students about the intricacies of the various cells of the immune system, (a game this reviewer would have difficulty playing), yet offered little information on prevention, other than that which promoted abstinence.

Lastly, few of the curricula provided any guidelines for the design and implementation of an AIDS education curriculum, or for the training of the teachers who would be responsible for presenting the material to the students. A large number of the curricula offered little beyond the suggested use of the *MMWR* supplement, *Guidelines for Effective School Health Education to Prevent the Spread of AIDS,* published by the Centers for Disease Control.[9] This supplement provides an adequate and basic overview of HIV transmission, yet it lacks specific information about helping sexually active young people practice safer sex.

Conclusion

For many states across the nation, the first step has been taken — the passing of mandates and recommendations for the design and implementation of sexuality

education and AIDS education curricula. However, in most cases, the increase in mandate numbers has not been matched by a corresponding increase in the comprehensiveness of curricula (in the breadth and scope of sexual subjects); indeed, a circumscribing of sexual topics is evident, which may be an attempt by the states to minimize controversy. As has been outlined here, much work lies ahead before students will have access to comprehensive programs that will adequately prepare them for healthy, sexual adult lives, and that will help them to adequately protect themselves from HIV infection. Serious issues have been raised in this article regarding the content of curricula — many of which will need to be addressed for the above goals to be realized — issues such as the training and certification of teachers, the design and evaluation of programs to fit students' needs, and the building of community support for sexuality education and AIDS education.

References

1. A state mandate is a requirement that students receive sexuality education and/or AIDS education; some states, such as Nevada, Minnesota, and Michigan, require their local school districts to develop such education programs.
2. Hereafter the word "curricula" will refer to both curricula and curricular guidelines.
3. SIECUS was unable to obtain copies of each of the curricula listed on the chart; for this reason the total number of curricula listed exceeds the number reviewed here.
4. Kenney, A. Sex education and AIDS education in the schools: A survey of state policies, curricula and program activities. Washington, DC: The Alan Guttmacher Institute, 1989. Schumacher, M. The NASBE HIV/AIDS education survey: Profiles of state policy actions. Alexandria, Virginia: National Association of State Boards of Education, 1989.
5. In addition to the material received, a research review was conducted at the library of the Alan Guttmacher Institute in Washington, DC of their collection of state curricula and curricular guidelines.
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7. New Jersey places its emphasis on appropriate expression within a very positive approach to sexuality, yet it also encourages students to develop "wholesome interests in the *opposite sex*" instead of referring to *adult sexual relationships*.
8. None of the states made a distinction between abstinence from intercourse vs. abstaining from being sexually active altogether; all assumed abstinence meant not engaging in any sexual behavior at all — another instance of their failure to address the range of sexual behaviors and their relative risks.
9. Centers for Disease Control. Guidelines for effective school health education to prevent the spread of AIDS, *MMWR,* 1988, 37(S-2).

SIECUS is grateful to the Alan Guttmacher Institute for use of their research library and to the National Association of State Boards of Education for its assistance in the preparation of this article.

SEX EDUCATION 2000:

A CALL TO ACTION

In June 1989, SIECUS convened "Sex Education 2000: A National Colloquium on the Future of Sexuality Education." This colloquium was cosponsored by the Alan Guttmacher Institute, the American Medical Association, New York University, the American School Health Association, the Association for the Advancement of Health Education, the Association of Junior Leagues, the March of Dimes Birth Defects Foundation, and the National Education Association. Sixty-five national organizations sent representatives to this colloquium.

The articles by Patricia Dietz, Ronald Moglia, and William Stackhouse were prepared as background papers for the colloquium, and are presented here in their entirety.

SIECUS has just published *Sex Education 2000: A Call to Action.* This report of the colloquium outlines 13 goals for the next decade and calls for comprehensive sexuality education for all children and youth by the end of the decade. Copies of the report are $12, ($10.80 to SIECUS members) and are available from Publications, SIECUS, 32 Washington Place, fifth floor, New York, NY 10003. Please add 15% postage and handling.

SIECUS
Position Statements 1990

Since its inception, SIECUS has taken stands on major sexuality issues confronting society. As SIECUS celebrated its 25th Anniversary, the Board of Directors revised and clarified its position statements. These position statements were approved by the SIECUS Board of Directors in September 1989. SIECUS members are encouraged to use the statements in whatever way may be appropriate to support advocacy efforts. They may be printed for broad distribution, as long as credit is given to SIECUS. These position statements will be available in the future in brochure format.

SIECUS Mission

SIECUS affirms that sexuality is a natural and healthy part of living and advocates the right of individuals to make responsible sexual choices. SIECUS develops, collects, and disseminates information and promotes education about sexuality.

Definition of Sexuality

Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. It deals with the anatomy, physiology, and biochemistry of the sexual response system; with roles, identity and personality; with individual thoughts, feelings, behaviors, and relationships. It addresses ethical, spiritual, and moral concerns, and group and cultural variations.

Sexuality Education

Learning about sexuality goes on from birth until death. Parents, peers, schools, religion, the media, friends, and partners all influence learning about sexuality for people at all stages of life. All too often, conflicting, incomplete, or inaccurate messages are received, and this frequently causes confusion.

SIECUS endorses the right of all people to comprehensive sexuality education. Comprehensive sexuality education addresses the biological, sociocultural, psychological, and spiritual dimensions of sexuality from 1) the cognitive domain (facts, data, and information); 2) the affective domain (feelings, values, and attitudes); and 3) the behavioral domain, (the skills to communicate effectively and to make responsible decisions).

SIECUS affirms that parents are — and ought to be — the primary sexuality educators of their children. SIECUS supports efforts to help parents fulfill this important role. In addition, SIECUS encourages religious leaders, youth and community group leaders, and health and education professionals to play an important role in complementing and augmenting the sexuality education received at home.

The Role of Schools

SIECUS endorses comprehensive sexuality education as an important part of the educational program in every grade of every school. SIECUS believes that classes conducted by specially trained educators complement the sexuality education given children by their families and by religious and community groups.

SIECUS recommends that school-based education programs be carefully developed to respect the diversity of values and beliefs represented in the community. Curricula and resources should be appropriate to the age and developmental level of the students. Professionals responsible for sexuality education must receive specialized training in human sexuality, including the philosophy and methodology of sexuality education. In addition, because sexuality issues touch on so many developmental issues of children and youth, SIECUS urges

that all teachers from prekindergarten through 12th grade receive a course in human sexuality.

Sexuality and Religion

SIECUS believes that organized religion can play a significant role in promoting an understanding of human sexuality as one of the most affirming expressions of equality, mutual respect, caring, and love among human beings.

SIECUS therefore urges religious groups, and spiritual leaders, to involve themselves, not only in sexuality education, but also in discussion of the sexual concerns of all their constituents, including the young, the elderly, the ill, and the physically or emotionally disabled.

SIECUS believes that it is important for religious institutions to minister and accord full religious participation to homosexual and bisexual women and men, and to others living in nontraditional relationships.

Sexuality and the Media

SIECUS urges the media to present sexuality as a positive aspect of the total human experience, at all stages of the life cycle. Because of the media's powerful influence on all aspects of society, and particularly upon children, SIECUS believes the media has a responsibility to present matters relating to sexuality with accuracy, without exploitation, and with sensitivity to diversity. SIECUS particularly condemns gratuitous sexual violence and all dehumanizing sexual portrayals.

Sexually Explicit Materials

SIECUS supports the use of a variety of explicit visual materials as valuable educational aids, to reduce ignorance and confusion, and to contribute to a wholesome concept of sexuality. Such visual materials need to be sensitively presented and appropriate to the age and developmental maturity of the viewer.

SIECUS supports the informed use of sexually explicit materials for educational and therapeutic purposes and also affirms adults' right of access to sexually explicit materials for personal use. SIECUS opposes legislative and judicial efforts to prevent the production and/or distribution of sexually explicit materials, insofar as such efforts endanger constitutionally guaranteed freedoms of speech and press. Furthermore, such actions could be used to restrict the appropriate professional use of such materials by sexuality educators, therapists, and researchers. SIECUS supports the legal protection of minors from exploitation in the production of sexual materials.

SIECUS deplores violence, exploitation, and human degradation in our society and objects to the use of sexually explicit materials that condone or promote these negative values.

Sexual Health Care

SIECUS believes that all individuals have a right to information, education, and health care services that promote, maintain, and restore sexual health. Providers of health services should 1) recognize the importance of sexual health for people of all ages and lifestyles; 2) understand how variations in health — such as those resulting from pregnancy, illness, disease, surgery, diet, and medication — may affect an individual's sexuality; and 3) assess an individual's sexual functioning and sexual concerns as integral parts of his/her health care and make appropriate interventions and/or resources available.

SIECUS advocates that education about sexual health concerns, needs, and therapies be integrated into professional training in all health care fields, at both entry and continuing education levels.

The Right to Choose Abortion

SIECUS deplores any attempts to undermine women's reproductive health rights. SIECUS believes that every woman, regardless of age or income, has the right to obtain an abortion under safe, legal, confidential, and dignified conditions, and at a reasonable cost. SIECUS supports the 1973 Supreme Court decision (*Roe v. Wade)* which affirmed the constitutional rights of a woman to seek and obtain an abortion. SIECUS advocates that no one be denied abortion services because of age, inability to pay, or other economic or social circumstances.

When making a decision to continue or terminate a pregnancy, SIECUS believes a woman is entitled to have full knowledge of the alternatives available to her and to have complete and unbiased information and counseling concerning the nature, the consequences, and the risks, both of the abortion procedure and of pregnancy and childbirth.

Contraceptive Care for Minors

SIECUS advocates that comprehensive information, education, and services in regard to contraception be readily accessible to all, regardless of gender, income, or age. SIECUS believes that health care providers have a particular obligation to help adolescents understand the issues surrounding conception, contraception, parenthood, and disease prevention.

SIECUS also believes that while it is generally desirable for parents to be involved in their children's contraceptive decisions, the right of every individual to confidentiality and privacy in receiving such information, counseling, and services is and should be paramount. SIECUS, accordingly, opposes any legislative or governmental attempts to infringe on this basic right and urges that all young people have ready access to low-cost prescription and nonprescription contraceptive methods.

Sexuality and Aging

Sexual feelings, desires, and activities are present throughout the life cycle. SIECUS supports the right of older adults to receive sexuality education, sexual health care, and opportunities for socializing and sexual expression. SIECUS advocates the continued education of professionals, support staff, and family members concerning the sexual feelings, attitudes, and behaviors of older individuals.

Sexuality and Persons With a Disability

SIECUS advocates that persons with a physical and/or mental disability receive sexuality education, sexual health care, and opportunities for socializing and sexual expression.

SIECUS urges social agencies and health care delivery systems to develop policies and procedures that will insure that their services and benefits are provided on an equal basis to all persons without discrimination because of disability. SIECUS advocates educational and training programs for health care workers and family members to enable them to understand and support the normal sexual development and behavior of persons with disabilities. SIECUS advocates that both those who are disabled and those who care for them should receive information and education to deter sexual abuse or exploitation.

AIDS

HIV infection and AIDS are major public health concerns that affect all segments of the population. SIECUS calls upon society to accord the crisis the highest priority and to provide funds and strategies to combat this epidemic. Therefore, SIECUS strongly urges the following: 1) continued governmental and private support for research on prevention and treatment; 2) provision of adequate and confidential medical, financial, and social service resources for HIV-infected persons and their loved ones; 3) educational programs to enlighten the public about the scientific facts, as they become available, in order to allay unwarranted fears; 4) education at all age levels about the transmission of HIV and how to prevent such transmission; 5) opposition to discrimination against HIV-infected persons, including people with AIDS; and 6) opposition to mandatory testing and quarantine.

Sexual Orientation

SIECUS believes that an individual's sexual orientation — whether bisexual, heterosexual, or homosexual — is an essential quality of humanness and strongly supports the right of each individual to accept, acknowledge, and live in accordance with his/her orientation.

SIECUS advocates laws guaranteeing civil rights and protection to all people regardless of their sexual orientation and deplores all forms of prejudice and discrimination against people based on their sexual orientation.

Masturbation

Masturbation, or sexual self-pleasuring, is a natural and nonharmful behavior for individuals of all ages and both genders. It can be a way of becoming more comfortable with and/or enjoying one's sexuality by getting to know and like one's body. It can be a form of sexual pleasure and/or release, whether or not one is engaged in a sexual relationship.

SIECUS believes that because masturbation is a private behavior, no one should be made to feel guilty for choosing or not choosing sexual self-pleasuring. Parents and other adults should try to avoid making children feel guilty or ashamed about masturbating, but should teach them that this is appropriately done in private.

Sexual Exploitation

SIECUS believes that sexual relationships should be consensual, with participants developmentally, physically, and emotionally capable of understanding the significance of the interaction. SIECUS condemns all exploitative and coerced sexual acts and behaviors including rape, incest, sexual harassment, and sexual abuse. SIECUS believes that forcing or coercing anyone to participate without consent in a sexual act is by definition exploitative and unethical.

SIECUS supports intensified efforts to prevent sexual exploitation through information and education programs, as well as through laws to deter and punish such acts. SIECUS also supports treatment programs to help victims of sexual exploitation. SIECUS advocates research to increase the understanding of the causes and effects of various forms of sexual exploitation and the development of appropriate treatment programs for offenders.

THE PROFESSIONAL PREPARATION OF SEXUALITY EDUCATORS

A Pivotal Factor for Sexuality Education

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To stimulate a thoughtful analysis about what and where sexuality education will be, or should be, by the year 2000, it is necessary to first recognize where we have been and where we are today.

In this age of AIDS, opinions on sexuality education can be heard everywhere. Typical may be the following:

> What is needed is "sane, quiet, complete sex-education of the American people" as the only way to control and eliminate this epidemic of sexually related diseases.[1] — *R.N. Wilson*

> "Parents should teach children about sex....Their failure to fulfill the responsibility of sex education leaves their children to the dubious wisdom of the streets."[2] — *P. A. Morrow*

> Endorsing sexuality education in schools, the U.S. Public Health Service commented, "As in many other instances, the school must take up the burden neglected by others."[3] — U.S. Public Health Service

> "Sex should be limited exclusively to marriage. Eliminate sex outside of marriage and a host of social problems from diseases to prostitution will disappear."[4] — *R.W. Chapman*

> "Instruction about sex education could be integrated into existing courses of study."[5] — *M. Bigelow*

Do the above statements sound familiar? Although they reflect the views of many professionals and citizens today, they were actually made three-quarters of a century ago — Bigelow's in 1916; Chapman's in 1911; Morrow's in 1904; the U.S. Public Health Service's in 1919; and Wilson's in 1912.

Why are they still current? There are many factors that have allowed the status quo to persist for so many years, but one factor is pivotal: the training of sexuality educators. It is imperative that preparation programs be designed for sexuality professionals that will take sexuality education into the 21st century. Only by doing this will we create a new perspective on this increasingly important area of concern.

The Professional Sexuality Educator

Before discussing professional training, the roles of a professional sexuality educator should be defined. Clearly, this is a professional who is involved in supporting the sexual health of people. But, what do we mean by sexual health? The World Health Organization defines it as having three basic elements:[6]

1. A capacity to enjoy and control sexual and reproductive behavior in accordance with a social and personal ethic.
2. Freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship.
3. Freedom from organic disorders, diseases, and deficiencies that interfere with sexual reproductive functions.

This definition illustrates that the role of a sexuality educator encompasses both education and health behavior. Today, we understand better than ever before how difficult it is to educate and help individuals change emotionally-laden behaviors. The connecting bridge between education and behavioral change is attitudes and sexual values. To educate in a helpful way about sexual health, training programs for sexuality educators must reflect this definition.

Contemporary Training Program Components

Information about the status of professional training in sexuality is not easily obtained. In 1983, Welbourne conducted a survey to assess the types of programs available in various disciplines.[7] The availability and frequency of training in almost all of the disciplines was negligible.

In the programs that were active, however, most indicated that their training included the following three components:

1. *The Cognitive Component.* Current facts and research findings are presented with the goal of providing a sound and comprehensive information base about human sexuality.

2. *The Affective-Attitudinal Component.* Opportunities are provided for trainees to share insights and knowledge about their sexuality. The overall goals are increased self-awareness and greater professional tolerance toward the sexual expression of others.

3. *The Skill Component.* Demonstrations and practice are used to help trainees learn ways of applying their knowledge and awareness about sexuality.

The components addressed by most training programs appear to be quite similar, but the actual methods used and the ultimate effectiveness of the training vary considerably. Basically, there are three methods that are currently used for training professionals:

1. *No formal instruction.* The individual is self-taught because of personal motivation or because it is required by curricula and/or other teaching materials.

2. *Programs and/or seminars.* The individual participates in inservice courses, continuing education courses, or short-term seminars.

3. *Academic courses or programs in schools of higher education.* The individual is enrolled in individual courses or a program that leads to a specialization or a complete degree in human sexuality.

The training method most frequently used is clearly the first one — *no formal instruction.* While this learning method is commendable and, one would hope, reflects the motivation of the learner, its effectiveness is the most difficult to assess. Self-teaching, however, is inevitably relied upon by every teacher at some time in his or her career. The form of structured training used most often is the second category: *programs and/or seminars.* Again, however, there is great variation in the method, length, and type of training received; such programs can range from a few hours of instruction to an intensive short course, such as a summer institute. Finally, *academic courses or programs in schools of higher education* may provide the professional with the most time-intensive and cognitively-rich training. Although a minority of professionals have had this experience, those who have tend to be the leaders or innovators in the field.

Naturally, the type of training program that is established or chosen will depend on many variables: the resources of the institution providing the training; the resources of the individual seeking the training; and the institutional support, time, need, finances, and training of the trainer. All of these are vital issues.

The most ideal training, however, for the year 2000 should consist of all three training methods. Professionals should be trained by academically-trained professionals who hold a degree in human sexuality, in a program that offers materials for self-teaching, that promotes participation in continuing education programs and seminars, and that supports follow-up training during the practice period.

The Current Status of Professional Training in Sexuality Education

Today, the best field to examine for the most current trends in professional training is AIDS education. AIDS education curricula and programs are receiving much attention, and they are receiving increasing support for implementation. At the present time, however, only three states, New Jersey, New York, and Wisconsin, plus the District of Columbia, have a comprehensive training program in sexuality education and AIDS education; 13 states have comprehensive training programs in AIDS education. However, interestingly, one can find no information on the academic training of any of the state's trainers.

One-half of the states require that teachers be certified or have training, or that they have both, in order to teach sexuality education or AIDS education. They are certified, however, in such fields as health education, health and physical education, home economics, biology, nursing, psychology, and special education.[8] It is obvious from this information that states see sexuality education and AIDS education as a discipline that falls under the auspices of other subject areas.

This conclusion has been supported by the recent study of sexuality education conducted by The Alan Guttmacher Institute.[9] The majority of the 50,000 teachers providing sexuality education are experienced educators who have training and experience in teaching the subject. However, their primary identity is as a teacher of another subject and not as a sexuality educator, and for most of them sexuality education represents a small proportion of their teaching load. Also, a real gap exists between teachers' perceptions of what needs to be done and what is actually being done. Sexuality education teachers have relatively little time to teach their material. The amount of time devoted to sexuality education, when it is taught, averages 11.7 hours in grade seven and increases to 18.3 hours in grade 12.[10]

A picture has emerged of a professional who is given inservice training and is expected to teach the subject in the context of the academic area in which s/he was originally trained. Statements such as the following by Forrest and Silverman are thus not surprising:[11]

> Sex education teachers say a lack of appropriate teaching materials is a common problem....Consequently, teachers must....develop many teaching materials themselves...developing their own materials adds to the danger that dated, inaccurate information may be passed on to students. Many teachers list student reactions or lack of interest as one of their most important problems, and this may also be a reflection of the adequacy of available teaching materials and strategies.
>
> The finding that about one-quarter of the teachers who discuss birth control methods in class do so only in response to student questions suggests that tension exists between what teachers teach and what students want to know.

There is a well-substantiated educational concept that must be acknowledged here: individuals tend to concentrate in areas in which they feel secure and confident. An excellent example of this is a study conducted of all public school health teachers in the state of Indiana.[12] The teachers were asked to indicate which of the 60 possible sexuality education topics they actually covered in their classes. One of the key findings of the study was that the individual teacher's attitudes toward sexuality was the most important factor in determining the inclusion of topics. The authors concluded that "education dealing with self-related attitudes and positive resolution of one's own sexuality concept would appear to have some value in the preparation of sex educators." Experts in the field of sexuality education have long agreed that comfort with the subject of sexuality directly influences their teaching. Their findings are indicators of an important issue: factual information is only part of the teaching that occurs in sexuality education; teachers also convey their feelings and attitudes about sexuality.[13]

Human Sexuality as a Complete Course of Study

It is clear that the current pattern used in training sexuality educators is one of short-term, inservice training, with the expectation that the sexual health content will be incorporated into other fields of official academic training. However, all evidence demonstrates that sexuality education is best treated as an individual subject area because of its complexities. It should be taught by trained professionals as a separate area. Sexuality education is an independent specialty that incorporates aspects of other specialties.[14]

"Hopefully, the research and requests of teachers will persuade more institutions to offer sexuality education or human sexuality as a complete course of study by the year 2000. And, hopefully, these academically-trained professionals will then help teachers receive the training and the tools they need to promote sexual health in our society."

Currently there are a handful of academic programs that are putting emphasis on the training of professional sexuality educators. In the United States, New York University and the University of Pennsylvania are the only two accredited institutions that are training and issuing degrees in this area; in Canada, the University of Montreal offers a masters degree. A number of institutions offer minors in this area of study. Hopefully, the research and requests of teachers will persuade more institutions to offer sexuality education or human sexuality as a complete course of study by the year 2000. And, hopefully, these academically-trained professionals will then help teachers receive the training and the tools they need to promote sexual health in our society.

Another benefit of having professionals trained in human sexuality as their primary discipline is that they can become the societal lobbyists for the field. All the wonderful prescriptions that were made at the turn of the century might not have failed if a core group of professionals had existed who were furthering their discipline.

This essay began with statements from the beginning of the 20th century. At that time, sexually transmitted disease was considered a social stigma and a punishment for immoral behavior. It was accepted that this punishment sometimes afflicted the innocent relative (i.e. spouse or newborn) of the immoral person. This concept was so well accepted by the professional medical community that it was called insontium, meaning infections of the innocent. In the case of opothalmia neonatorum (blindness at birth), caused by a child being born to a mother with a gonorrheal infection, it was widely accepted in 1910 that this "was the fateful expression of ignorance and criminal carelessness, the workings of the relentless laws of Nature which visits the sins of the fathers upon the children."[15] The tragedy of this is that, almost 30 years earlier, a German obstetrician discovered that placing a drop of silver nitrate solution in a newborn's eyes prevented blindness. The medical solution was there, but because there was no core of human sexuality professionals to interpret the findings for the public, society was not able to use it.

Let us work to improve sexuality education so that, by the beginning of the 21st century, our children will not have to suffer from sexual blindness because of our inability to train our professionals in the best methodologies for overcoming sexual ignorance.

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YOUTH-SERVING AGENCIES AS EFFECTIVE PROVIDERS OF SEXUALITY EDUCATION

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The mention of well-known, national youth-serving agencies, (YSAs), evokes the image of swimming lessons, summer camps, and cookie sales, but not necessarily the image of comprehensive sexuality education programs for youth. Yet today, youth-serving agencies are often involved in the latter, as well as the former, endeavors. Together, they provide over two million youth each year with sexuality information and skills.

Second only to schools in the number of youth they serve, youth-serving agencies are excellent providers of sexuality education programs, both because they work with large numbers of youth, including many underserved youth, and because they provide an environment that is informal and conducive to creative and experiential learning. Some YSAs reach youth who have dropped out of school. Others reach youth who have not received sexuality education programs in their schools. The people who work at YSAs often build close relationships with the youth in their programs which allows for better communication and more effective educational efforts. All YSAs also strive to enhance self-esteem and leadership skills among youth — goals which go hand in hand with the goals of sexuality education.

Effective Sexuality Programs

Effective sexuality programs consist of several different and important components:

First, they need to incorporate experiential exercises such as role-playing. An evaluation of 15 sexuality programs found that only the programs which provided a directly relevant, experiential component had a clear impact upon participants behavior.[1]

Second, they need to cover a variety of important subjects. In a survey of sexuality education experts, several topics were rated as "extremely important," including contraception, abortion, homosexuality, myths, values, exploitation and assertiveness, and the emotional and social aspects of sexuality.[2]

Third, sexuality education needs to be skill-based. Adolescents' abilities to make important decisions, to communicate effectively, and to access the health care system are just a few of the many necessary skills needed to avoid pregnancy and HIV infection.

During the last decade, YSAs have moved strongly into the implementation of sexuality education programs. In 1977, virtually no YSA had developed or implemented a national program on sexuality. Some YSAs, however, such as the YWCA of the USA, did have sexuality policies. By the early eighties, however, when the problem of teenage pregnancy began to receive national attention and was being documented in numerous studies and reports, YSAs were spurred to provide sexuality education. Since that time, their sexuality education programs have been greatly expanded. Recently, they responded to the threat of AIDS and HIV among young people by addressing this issue in their programs as well.

In 1989, the Center for Population Options (CPO) surveyed 19 national YSAs by mail, and followed up by telephone with those who did not respond. Overall, 18 YSAs participated in CPO's survey.[3] Of those YSAs, nine have developed one, and in some instances, two national programs on sexuality. In addition, the majority are now providing a wide range of support services to enhance their affiliates' individual sexuality education programs. These services include comprehensive training, workshops at national conferences, small grants, awards for affiliate programs, and the development and identification of appropriate educational materials. The following is a summary of the information gathered from the surveys.

Organization Policy Statements

Policy statements clarify an organization's position on certain issues, and express its commitment to develop and support programs relating to those issues. The majority of YSAs surveyed have a policy in one or more of the following areas: sexuality education, teenage pregnancy prevention, HIV/AIDS prevention, reproductive rights, and access to contraceptive services. Of those surveyed, ten YSAs have policies supporting sexuality education; seven have policies that state the need to prevent teenage pregnancy; seven have specific policies on AIDS;

Youth-Serving Agency Policies[4]

Support Sexuality Education:

American Home Economics Association (AHEA)
Boys Clubs of America
Camp Fire, Inc.
Girls Scouts of America
Girls Clubs of America (GCA)
March of Dimes Birth Defects Foundation
National Network of Runaway and Youth Services
National PTA
YWCA of the USA (YWCA)

Teen Pregnancy Prevention:

American Red Cross
AHEA
March of Dimes Birth Defects Foundation
National Network of Runaway and Youth Services
YWCA

HIV/AIDS:

American Red Cross
Camp Fire, Inc.
GCA
Girl Scouts of America
National Network of Runaway and Youth Services

Support an Adolescent's Right to Contraceptive services:

AHEA
GCA
National Network of Runaway and Youth Services
National PTA
YWCA

Support an Adolescent's Right to Choose Abortion:

AHEA
National Network of Runaway and Youth Services
YWCA
GCA

five support an adolescent's right to have access to contraceptive services; and four support an adolescent's right to choose abortion.

YSA National Sexuality Programs

Nine YSAs have developed national sexuality education programs for their affiliates with goals that vary from preventing adolescent pregnancy, to reducing the risk of HIV infection among youth, to delaying sexual intercourse. The programs also vary in length and in the amount of information covered. The shortest program is five hours; the longest is 30 hours. Almost all programs require parental permission, and seven include special workshops or materials that directly involve parents. Seven of the national programs have been evaluated, and one will be evaluated within the next year. All of the programs focus on knowledge and skills, but the subject areas and skills taught vary substantially. The subject areas most often covered in the sexuality education programs include: the consequences of teenage pregnancy, sexually transmitted diseases, anatomy, menstruation, family relationships, drugs and alcohol, myths and stereotypes, and dating. The less frequently addressed subjects are pregnancy tests, adoption, abortion, and homosexuality. The skills often covered include communication, avoiding risky behaviors, decision-making, values clarification, and assertiveness. A few of the programs cover the following skill areas as well: public speaking, contraception, employment, parenting, counseling, accessing health care, and listening.

The *American Red Cross* has developed two sexuality education programs — AIDS Prevention Program for Youth and Reaching Adolescents and Parents. The AIDS Prevention Program reaches approximately one million youth each year with five hours of HIV prevention and AIDS education. The program consists of a 25-minute video/film; a student workbook; a leader's/teacher's guide; and a brochure for parents, *Children, Parents, and AIDS*. The program recommends reducing the risk of HIV infection by saying "no to drugs" and "no to sex." The goals of the program are to decrease HIV infection by promoting sexual abstinence and by increasing contraceptive use for the sexually active. The objectives are to increase educators' acceptance of the need for AIDS education in the schools; to increase teachers' abilities to provide AIDS education; and to increase parents' abilities to discuss AIDS with their children. This program was evaluated through focus groups and field tests.

The American Red Cross is currently updating the information in their brochure and has two other major HIV programs in development — a Black Youth Project and an AIDS Prevention Program for Hispanic Youth and Families. Through the latter program, the American Red Cross will create and distribute materials to reach approximately 150,000 Hispanic youth.

The second Red Cross sexuality education program, Reaching Adolescents and Parents, has several goals: to decrease teen pregnancy, to decrease teen births, and to promote sexual abstinence. In 11 to 15 hours of education, youth, ages 11 to 14, learn about nine different topics, including menstruation, the consequences of teen parenthood, drug and alcohol use, and dating. They also

learn a variety of skills, such as communication, decision-making, assertiveness, and accessing the health care system. In addition, a two-hour workshop with parents and youth focuses on improving communication. Tested in 20 local chapters, the program now reaches about 4,000 youth. The curriculum soon will be available for all chapters. Evaluation of the program, which included pre- and posttests, found positive changes in knowledge, attitudes, and behaviors among participating youth.

The *American Home Economics Association's (AHEA)* program, Taking Charge, developed in 1987, offers more than 30 hours of educational programming to 12 to 14-year-old males. The program seeks to decrease teen pregnancy, promote sexual abstinence, and improve employment opportunities for the youth involved. The objectives are to increase information, build skills, change attitudes and behavior, and involve parents in workshops and interviews. The curriculum includes a teacher training program. Implemented in three AHEA affiliates, Taking Charge reached 200 youth in its first year and is projected to reach 30,000 students, teachers, and administrators by 1990. AHEA will evaluate the program within the next year.

The *Boys Clubs of America (BCA)* has developed two national education programs, Smart Moves, a substance abuse/pregnancy prevention program, and Body Works, a health promotion program. Smart Moves, field-tested in 10 Boys Clubs and Boys and Girls Clubs, includes three different components: *Start Smart* teaches resistance skills to 10 to 12 year olds; *Keep Smart* involves parents and helps them to improve their communication skills with their children; and *Stay Smart* includes social skills for youth from 13 to 15. BCA estimates that 38,000 youth in 175 clubs participate in the program. Body Works, implemented in 600 clubs, strives to develop healthy attitudes and practices among youth through peer and social pressure, health screening, and follow-up services. The 200 educational activities in the program fall within five broad areas: personal health, total fitness, emotional health, sexuality/family, and survival. BCA's AIDS information guidebook outlines how program leaders can incorporate HIV/AIDS education into both Smart Moves and Body Works.

The *Girls Clubs of America (GCA)* has a primary commitment to providing health promotion, sexuality education, and pregnancy prevention services to its members, and reaches approximately 200,000 youth each year with sexuality education. Its latest approach to sexuality education is its comprehensive Preventing Adolescent Pregnancy program, which will be implemented throughout the national organization. Based on the current research findings that "it's not enough to provide teenagers with sex education and with access to birth control information and services," the program also works to build a variety of skills, such as communication, vocational planning, and goal-setting through four curricula.[5] *Growing Together,* a four-session series, works to improve parent-child communication and directly involves mothers, fathers, guardians, and 9 to 11-year-old daughters. *Will Power/Won't Power,* targeted to girls, ages 12 to 14, focuses on decision-making and assertiveness training. In order to "encourage girls to view personal hygiene, reproductive health, and contraception in the context of general health and wellness," the *Health Bridge* curriculum links comprehensive health care services to educational information through the involvement of local hospital, clinic, and medical school personnel. The fourth curriculum, *Taking Care of Business,* targeted to 15 to 18-year-old females, provides 15 hours of educational programming that helps young women to develop their careers and life goals, and to understand the impact that childbearing may have on reaching these goals.

GCA is evaluating the Preventing Adolescent Pregnancy program through a quasi-experimental design. It has administered pre- and posttests to participants and has collected survey data from all club members of the same age.

In 1986, GCA began incorporating HIV/AIDS education into its current programming, including its health curricula. During the next four years, GCA will develop HIV/AIDS materials and training programs, provide ongoing technical assistance, and implement an awards program for affiliates with outstanding programs.

"Overall, YSAs should be applauded for their contribution to providing sexuality education to our youth. Given the momentum gained in the last decade, it can be assumed that YSAs will continue to take a leadership position on this front into the next century."

The *Girl Scouts of the USA* recently developed *Decision for Your Life: Preventing Teenage Pregnancy,* a curriculum for Girl Scout leaders. The program intends to decrease teen pregnancy and births, to promote sexual abstinence, and to teach parenting skills to females ages 12 to 18. The program focuses on the consequences of teen parenthood and on skill development in the areas of communication, decision-making, assertiveness, values clarification, parenting, and avoiding risky behaviors. The Girl Scouts of the USA will be designing a human sexuality program in 1990 for Girl Scout Councils that will include a section on how to train Girl Scout leaders. Overall, 70% of Girl Scout Councils have implemented some form of sexuality education.

The *March of Dimes Birth Defects Foundation* developed in 1981, and implemented nationally in 1986, the Project Alpha sexuality education program in collaboration with Alpha Phi Alpha Fraternity, Inc. The program "explores the problem of teenage pregnancy from the male perspective and helps young men learn about their role in responsible childbearing." In 10 hours, the program covers three major components: *Knowledge Building,* which includes subjects such as anatomy and physi-

ology, the legal, health, and psychosocial consequences of teen pregnancy, drug and alcohol use, myths and stereotypes, and sexually transmitted diseases; *Motivation,* which focuses on developing skills such as decision-making, values clarification, and avoiding risky behaviors; and *Taking the Message Back,* which urges young men to share information with their peers and community. Seventy-five of 132 affiliates currently offer the program, reaching more than 3,000 youth each year. In addition, the March of Dimes Birth Defects Foundation estimates that 90% of its affiliates provide some form of sexuality education.

The *National Congress of Parents and Teachers' Association's (National PTA)* overall philosophy encourages parents to communicate with their children about many issues, including health. This philosophy guides their two programs related to sexuality education. One of them, The Parenting Box, uses 16 cards that suggest issues for local PTAs to address at meetings. Each card covers one subject related to sexuality such as HIV/AIDS, drugs, alcohol, self-esteem, and puberty. In addition, each card includes specific outlines, exercises, and resources. More than 3,500 local PTAs offer the program, reaching approximately 70,000 parents each year. The pamphlet, *How to Talk to Your Preteen and Teen about Sex,* supplements the program.

The National PTA's second program focuses on HIV/AIDS. Here parents are encouraged to talk to their children about HIV prevention, and local PTAs are taught how to develop and implement an HIV/AIDS educational program as part of comprehensive sexuality education in schools. The National PTA helps local affiliates become more actively involved in HIV prevention through materials development, awards for outstanding local PTA HIV/AIDS programs, and a monthly HIV/AIDS newsletter. The National PTA *AIDS Education at Home and School: An Activity Guide for Local PTA Leaders,* is a comprehensive booklet designed to help PTAs plan HIV/AIDS educational activities through reproducible pamphlets and sample meeting agendas. A pamphlet, *How to Talk to Your Teens and Children about AIDS,* supplements the guide.

The *National Network of Runaway and Youth Services* has developed an HIV/AIDS education program, Safe Choices, for high-risk youth. The program provides training for staff at runaway shelters, residential treatment facilities, group homes, detention facilities, street outreach programs, hotlines, foster family programs, and other agencies that serve high-risk youth. The program covers six areas: corporate/board policy; staff training; group sessions; street outreach; hotlines; and individual/family counseling. The curriculum includes information on HIV transmission, drugs and alcohol, safer sex strategies, and the pros and cons of HIV antibody testing. The skill-building exercises address communication, decision-making, listening, values clarification, avoiding risky behaviors, accessing the health care system, and condom use. Successfully field-tested at six residential programs in 1988, the curriculum soon will be released to local agencies. Overall, 60% of local agencies are providing a formal sexuality education program, and all provide information, counseling, and referrals for health and social services.

The *YWCA of the USA* began a pilot in 1984, the Expanded Teen Pregnancy Prevention Program, which includes the development of a peer-mediated sexuality education program, a board game, and several educational videos. Peer Approach Counseling by Teens (PACT) targets youths, from 15 to 18, with over 30 hours of knowledge- and skill-building exercises to strengthen their decision-making skills, their ability to communicate about sensitive topics, and their sense of control over their lives and choices. The program's ultimate goal is to decrease teen pregnancy, births, and HIV infection, and to increase contraceptive use. Once the youth are trained, they share their information and skills with other youth, ages 11 to 18. Through PACT's pilot test, over 7,000 youth have been reached and thousands more will be educated as the program is implemented nationally.

Choices or Chances, a board game for adolescents, covers a wide range of issues and situations in which decisions about relationships and life planning must be dealt with by the players. It is geared to helping youth make better decisions about reproductive health and relationships. The game develops many of the participants' skills, including decision-making, listening, assertiveness, and values clarification.

The YWCA has also developed three trigger films targeted to early adolescents. *It's Okay to Say No Way,* for 8 to 11 year olds, reinforces the message that it is all right to wait to have sexual intercourse; this video is used by more than 120 YWCA affiliates. Two other new videos, *Lovesick* and *Crush,* deal with emotions around first relationships and how to handle them.

Community-Based Affiliate Programs

In addition to national YSAs' efforts, local affiliates have often met the needs of their communities by designing their own programs. At least five local YMCAs have developed their own teen pregnancy prevention programs. The Eastern District Branch YMCA, located in Brooklyn, New York, serves approximately 1,000 youth through peer counseling, general sexuality education, and GED preparation courses; the Madisonville Branch YMCA in Cincinnati, Ohio, has developed a peer education and counseling program; and the Winston Lake Family Branch YMCA in Winston-Salem, North Carolina reaches 200 youth through an outreach and after-school program. In other agencies, some locally-developed programs have been replicated by other affiliates. For instance, Big Sisters of Denver has developed a sexuality education program, Life Choices, which has been offered in more than 30 affiliates, reaching 700 youth each year. The Beaumont Camp Fire Council of Beaumont, Texas developed Sex in Perspective which has been replicated in several other councils.

The National 4-H Council estimates that most state extension offices have developed a program to reduce teen pregnancy. Types of programs developed include: building communication skills between parents and youth; providing information to youth on the consequences of teen pregnancy; building self-esteem and vocational skills; and developing parenting skills for young mothers.

Affiliates also have responded to the need for HIV prevention and AIDS education for the youth they serve. The Sequoia YMCA in Redwood City reaches 500 out-of-school, homeless, and delinquent youth with HIV prevention and AIDS education information. The Girls Clubs of New York developed separate HIV prevention and AIDS education components for early adolescents, older adolescents, and parents.[6]

Summary

Overall, YSAs should be applauded for their contribution to providing sexuality education to our youth. Given the momentum gained in the last decade, it can be assumed that YSAs will continue to take a leadership position on this front into the next century. Some of the national YSA programs and curricula provide an excellent base on which to build, as their design is based on the latest research that documents that knowledge is not enough; they provide material appropriate to adolescents' stages of growth and development, so that early adolescents learn assertiveness skills and how to delay sexual intercourse, while older adolescents who engage in sexual intercourse learn how to use, and where to obtain, contraceptives; they involve experiential learning processes, so that youth will incorporate new knowledge into their own behavior; and, finally, they incorporate comprehensive information and skill areas.

However, only a few YSA programs touch on knowledge areas, such as homosexuality, abortion, and adoption, and on skill areas, such as listening, employment, contraception, and accessing the health care system. In the future, YSAs should consider expanding their programs to include these, sometimes controversial but absolutely necessary, knowledge and skill areas so that youth can receive effective and comprehensive sexuality education.

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SEX EDUCATION 2000

Goals for 1990-2000

Mission: To assure that all children and youth receive comprehensive sexuality education by the year 2000.

Goal 1: By the year 2000, sexuality education will be viewed as a communitywide responsibility.

Goal 2: By the year 2000, all parents will receive assistance in providing sexuality education for their child(ren).

Goal 3: By the year 2000, all schools will provide sexuality education for children and youth.

Goal 4: By the year 2000, all religious institutions serving youth will provide sexuality education.

Goal 5: By the year 2000, all national youth serving agencies will implement sexuality education programs and policies.

Goal 6: By the year 2000, the media will assume a more proactive role in sexuality education.

Goal 7: By the year 2000, federal policies and programs will support sexuality education.

Goal 8: By the year 2000, each state will have policies for school-based sexuality education and assure that mandates are implemented on a local level.

Goal 9: By the year 2000, guidelines, materials, strategies and support for sexuality education will be available at the community level.

Goal 10: By the year 2000, all teachers and group leaders providing sexuality education to youth will receive appropriate training.

Goal 11: By the year 2000, methodologies will be developed to evaluate sexuality education programs.

Goal 12: By the year 2000, broad support for sexuality education will be activated.

Goal 13: In order to realize the overall goal of comprehensive sexuality education for all children and youth by the year 2000, SIECUS calls upon national organizations to join together as a national coalition to support sexuality education.

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THE IMPACT OF RELIGION ON SEXUALITY EDUCATION

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This article is intended to stimulate creative thought and discussion regarding sexuality and religion in the year 2000 within the context of the United States and its values. As it was SIECUS, the Sex Information and Education Council of the United States, who invited individuals and representatives of organizations to join together in a national colloquium, "Sex Education 2000: A National Colloquium on the Future of Sexuality Education," it may be useful to note the "U.S." in SIECUS — particularly when considering the role that religion plays in respect to our sexuality.

Throughout the history of our nation, persons have come to the United States in search of religious liberty. And, while there have been, and continue to be, attempts by sectarian religious adherents to impose their particular values upon all, the United States' value of religious liberty has prevailed. Religious pluralism, which is nurtured by this value, is deeply connected to such American values as free speech, access to information, and intellectual freedom. Many American religious adherents bring these central values into integral interaction with their personal religious involvement, which often results in a dynamic combination of American values, a deep and living faith, and a nonsectarian respectfulness of beliefs and cultures other than their own — a fact often ignored by religious leaders. Such American values provide an important context in which to consider religion and sexuality in the year 2000.

In recent years, the place of non-Judeo-Christian world religions has become more established in America and, as such, will contribute to our process of dynamic growth, but this article will focus only on Judeo-Christian examples. However, the various critical approaches applied to the Judeo-Christian examples, herein, could likewise be applied to other religious belief systems.

On the other hand, it is important to keep in mind that religion has been a major ideological source of oppression in regard to sexuality. The following contemporary examples of how certain sectarian views challenge our American values are illustrative of this continuing dynamic. Recently, the American Family Association, a fundamentalist Christian organization, pressured advertisers not to support *"Roe v. Wade,"* an NBC television dramatization of the 1973 Supreme Court decision; NBC, however, indicated that it would air the movie with, or without, advertising support. The *New York Times* was filled with letters to the editor regarding the decision to appoint a Roman Catholic priest to head the New York Public Library, raising concern that religious values might be imposed upon important decisions made by the library. And, lest we forget, some of the offensive passages in *The Satanic Verses* that led to the death threats against Salman Rushdie were made all the more damning for their sexual elements and the challenge that they posed to freedom of the press in America.

Opposing Religious Perspectives on Sexuality

At first glance, one might consider a sexual theology — based upon scripture, tradition, reason, and experience — to be a moderate road to understanding. Upon reflection, however, it is clear that the inclusion of reason and experience has led some to view such a theology as a radical progressive view tending toward "secular humanism." This fact underscores the importance of examining two opposing perspectives on sexuality and theology, which may be seen broadly as two separate camps: the dualistic camp and the holistic camp.

The Dualistic Camp of Religious Adherents

Those in the United States, who stand in the way of the goals of organizations such as SIECUS, tend to share the assumptions that underlie a dualistic paradigm, which include: patriarchy, dualism of body and spirit, a strong procreative ethic, a denial of the relationship of erotic love to divine grace, a strict set of external rules to govern sexual behavior, and a strong condemnation of homosexuality.[1] Religious adherents in this camp tend to coalesce around specific, emotionally charged issues such as abortion, homosexuality, and pornography. This is not comprehensive sexual theology.

An example of the impact that such coalescing has on the way in which these religious adherents would present sexuality can be found in the following examples. In an examination of themes and topics in religious television programming, Abelman and Neuendorf found that the social topics (cited most often were death and dying and mass media) were more frequently presented than political topics.[2] Among the sexuality-related topics only one, marriage, was dealt with in an approv-

ing way; other topics, such as sexual behavior, abortion, homosexuality, and pornography were dealt with in a disapproving way — when they were presented at all.

Religious adherents in this group tend to take conservative positions on political and social issues. In an examination of the connection between religious variables and political attitudes and behaviors among activists in the Ohio Moral Majority, Wilcox found conservative positions on ERA, abortion, and women's roles were highly correlated with religious beliefs.[3]

When Swatos examined the attitudes of the activists who supported the National Federation of Decency picket against 7-Eleven stores in 1984 — in regard to the importance of the various political, cultural, and social variables which may be contributing to society's current problems — pornography, not surprisingly, was seen as contributing the most, and sexuality education was not far down on the list.[4] Swatos' conclusion about this particular group also may be useful in our overall considerations, as he mentions other potential sources of their particular social activism: "Although it is difficult to specify all the roots of these leaders' principles, values, and beliefs, they clearly embrace a cultural fundamentalism characterized by familism, Christian religious fundamentalism, and a rural life-orientation."[5]

The above views are further amplified by Viguerie who notes that it is important to remember that the Christian Right sees persons — such as secular humanists, abortionists, and homosexuals — not only as deviants, but views their activities as being major causes in the breakdown of American moral standards.[6]

The Holistic Camp of Religious Adherents

On the other hand, religious adherents, who stand by the goals of organizations such as SIECUS, are found among a wide variety of faith groups. These persons and organizations can be grouped together by their common agreement with the assumptions Yates has outlined as shaping a holistic (Christian) paradigm of sexuality. These assumptions are:[7]

1. Sexuality should be viewed in light of an egalitarian perspective in which men and women are considered to be equal to one another.
2. The morality of homosexual expression should be judged much as we judge heterosexual expression: in light of whether it enables an individual to realize wholeness.
3. Sexuality, as part of creation, is good.
4. Sexuality should be understood to be related to both body and spirit.
5. Sexuality should be seen as a dimension of the self that is expressed in all forms of love — forms that together constitute holistic love.
6. Sexuality should be seen as a means through which persons can know the grace of God.
7. Rules governing sexual behavior are important to sexual health and wholeness.

These assumptions presently underlie the involvement of many of the adherents of this group in social activism, and in education and service programs.

The Responses of Religion to Human Sexuality

Enormous sociocultural changes have taken place during the lives of the parents of today's school-age children. Religious institutions have responded by reexamining and remaking symbols through social/political action within religious institutions and within society, through service to members and to the public, and through education of members and in partnership with the public.[8] While the primary focus of this consideration of responses focuses on education, the roles of religion in symbol, action, and service provide a dynamic backdrop for religious responses to sexuality education. Because these features of religious responses are so dynamically interrelated, each will be briefly presented here.

The primary avenue by which religious symbols — such as the image of God and the image of the religious leader — are presently being reshaped in the United States is through the impact of feminism. Two important features of the contribution of feminism to theology are: the reshaping of religious symbols, and the reshaping of perspectives which grow out of women's ways of knowing (ways of knowing more inclusive of feelings and less strictly based upon conceptual abstractions). Feminist critiques, that are leading individuals and institutions to reexamine their sexist images of God and the use of nonsexist language within religious communities, are having a potent effect upon religious experience and community. Moreover, women in leadership are themselves symbols of a move away from patriarchy with all of its implications; women's ways of knowing and doing are challenging the historic male ways of knowing and doing. Allowing ourselves — men, women, and institutions — to be informed by the feeling aspects of women's ways of knowing grows from this ground. This reshaping has become more pronounced in recent years, and the impact it will have on the sexual/religious experience of individuals is yet to be fully seen.

Such perspectives are having a great effect on the social/political activity taking place within religious institutions and within society. Within religious institutions, persons historically disenfranchised are being recognized and injustices are being redressed. Women, racial/ethnic communities, the disabled, and gays/lesbians are seeking support in their involvement in the religious life of their communities — and they are getting support. In addition, their involvement in religious community and leadership is being encouraged in many different ways, which has resulted in a more robust diversity within religious bodies. As religious individuals and institutions pronounce this message of inclusiveness within society, the impact is, and will be, to strengthen the foundation for inclusiveness of secular responses to sexuality.

Until recent years, the response of religion to human sexuality-related concerns through their service activities was limited and traditional in scope. Programs on marriage preparation and enrichment, family life, and orphaned and unwanted children have long been part of religious-based service. But recently — and, again, often developed in large part out of the needs expressed as women have shared their experiences — religious institutions and individuals have become involved in service

programs that relate to a broader range of concerns, including family communication about sexuality, adolescent sexuality, reproduction, pregnancy termination, gay/lesbian concerns, sexual violence, and AIDS. Existing religious agencies are now incorporating these concerns into their goals. Support groups now meet in, and are sponsored by, local congregations. And religiously affiliated institutions have come into being that have been specifically developed to provide specialized service in these areas.

The heterogeneity of religious responses to sexuality and sexuality education cannot be emphasized enough. They vary both across faith groups and within faith groups. The religious responses also vary according to whether external support is provided for public sexuality education programs and/or whether internal support for sexuality education programs are provided for members within a religious community.

External Religious Responses

External religious responses to public sexuality education may be examined from many angles. A sexuality educator, searching for religious support, must examine his or her potential for support from these different angles. The relative extent to which a religious body incorporates such factors as scripture, tradition, reason, and human experience into its theology of sexuality, combined with its organizational nature (hierarchical or not), provides the most comprehensive predictor of the potential for support. (I believe this applies to Christian and non-Christian bodies alike.)

Religious bodies, which rely heavily upon scripture and tradition at the relative exclusion of experience, tend to be the least supportive, if not against, public sexuality education; these include the more fundamentalist and/or orthodox traditions. Such traditions also tend to be more hierarchical in their make-up. As such, even if lower level organizations (e.g., local congregations) or individual members are supportive, their support may be potentially muted by a higher authority.

On the other hand, those religious bodies that include reason and human experience in the way they deal with sexuality are more likely to be supportive. When the latter are hierarchical, support can generally be mobilized down the line (e.g., the Episcopal Church). When they are relatively nonhierarchical, support may be encouraged down the line, but it is not required. Individuals, and local bodies of this sort, may opt for even more progressive and specific stances than do their national bodies in support of public sexuality education. Using this approach to look at potential levels of support, one could develop a plan for the mobilization of support for public sexuality education at national, regional, and local levels.

Internal Religious Responses

Sexuality education at the local level, when it exists within religious traditions, is often the project of a progressive, risk-taking clergy with a supportive membership and is generally aimed at youth.

Institutional support from national organizations has varied widely. The following are four examples of institutional involvement with religiously-based sexuality education programs that illustrate their different approaches.

Unitarian Universalist Association. This program continues to get excellent reviews. The Unitarian Universalist Association's sexuality curriculum by deryck calderwood, *About Your Sexuality,* is widely considered the most comprehensive of religious sexuality education programs.[9] The program is a package curriculum, with a wide variety of materials and resources that are updated periodically, such as their recent AIDS update. While aimed at youth, the program's contents cover the entire lifespan. In addition, leaders who present the program receive training, which distinguishes this program from other religious sexuality education programs. Although clergy and lay providers of religious education at the local level may be intelligent and enthusiastic, their previous training is not likely to have prepared them for the response of participants in the sexuality education programs they present.

Joint Educational Development. In the early 1980s, a body devoted to joint curricular development among Protestant Christian denominations, Joint Educational Development, published a curricular series on sexuality for preadolescents and teens. These program modules were designed to be presented by local church school leaders. Each module was designed for a specific age group: *Growing Up To Love* for grade school; *The Search For Intimacy* for junior and senior high school; and *Teenage Pregnancy: The Kids Next Door* for high school. These materials continue to be widely used; their brevity allows them to be easily included in a church school's curricular calendar. However, while factually sound, they lack the depth and comprehensiveness of *About Your Sexuality.* These materials have not been evaluated and therefore the question of their impact, especially when presented by leaders and educators without special training in sensitivity to sexuality-related concerns, has not been explored.

The Episcopal Church. In 1987, the Episcopal Church produced *Sexuality: A Divine Gift, A Sacramental Approach to Human Sexuality and Family Life.* This curriculum was designed to engage members of local congregations in a process of communal self-exploration and in the sharing of experience, which was to be followed by a series of educational presentations based on this exploratory process. This innovative and challenging curriculum met with immediate strong resistance, for its openness to the diversity of human experience, for the theological responses to such experience, and for its lack of formal statements of norms. Copies were withdrawn from sale, and in 1988 an addendum was published entitled *Continuing the Dialogue — Sexuality: A Divine Gift.* The addendum included various essays, both pro and con, critiquing the original curriculum. Together, these two documents make for a curriculum that tests the metal

of a seasoned, theologically trained, sexuality educator. A brief summary of the above dilemma, taken from an article in the *Washington Post,* illustrates an oft-occurring predicament that forces many a religious sexuality program in a Christian setting to succumb: "In part, the controversy pits those who want the church to reiterate the Bible's thou-shalt-nots about sexual behavior against those who would help believers to determine a course of conduct based on broad Biblical principles of integrity, love, and responsible concern for others."[10]

The United Church of Christ. In 1990 the United Church of Christ (UCC) will publish a congregationally-based sexuality program by Eleanor Morrison (author of the widely used *Values in Sexuality*) and Melanie Morrison, tentatively entitled *Claiming our Humanness: Human Sexuality in Ministry and Mission.* This program is notable in that it combines the approaches found in all three of the previously noted curricula. Numerous additional materials will be appended to it, leadership training will likely be an element of distribution, and developmentally appropriate materials will be utilized. In addition, a covenantal, congregational, self-survey of needs and experiences will be part of the process of implementing the curriculum.

Most notable is that this curricula is based upon a large scale, sexuality-related needs assessment, *Ask The Churches: A UCC Survey of Needs for Program Development,* conducted by the United Church Board for Homeland Ministries from 1984 to 1986. A comprehensive questionnaire was distributed to members of 75 congregations in 11 metropolitan areas. More than 2500 completed surveys were returned and analyzed, representing a 20% return. The findings of this study may be useful to those planning sexuality-related programs (of all kinds) within a religious context, especially sexuality education. Eighty-three percent of the respondents recommended that sexuality and sexual ethics be part of the churches' educational programs, while 17% opposed, and 2% strongly opposed, this. Similar levels of support were found for other sexuality-related activities, such as making referrals, pastoral involvement, providing opportunities for dialogue, speaking out on sexuality-related injustice, and encouraging mutual support. Also, 72% agreed that the church should offer guidelines for individuals, while only 16% thought the church should give specific rules for sexuality-related behavior. Support was found among all types of churches and members. It was strong throughout. In other words, 80% of any UCC congregation would be likely to be supportive of the above sexuality-related activities or programs, with only a minority opposed. Given the organizational structure of the UCC, the documented numbers in support meant that a program meeting the needs of the majority could be produced for them.

The UCC program, *Claiming Our Humanness* is most notable in that it will include a process for planning various ministries in human sexuality, including the sexuality education of members.

The Future — Obstacles and Reasons for Hope

There are several large obstacles inhibiting a robust involvement by religious organizations in sexuality-related service and education.

First among them is the allocation of scarce resources among competing demands. Almost all national religious organizations have cut back staff and programs in recent years, and innovative and/or controversial programs have often been the first to go. Even recently, already developed programs, which focus on such long-ignored areas as sexual violence against women, are in jeopardy of not receiving adequate funds.

Second, the documentation of need, as undertaken by the UCC, and the mobilization of grassroots support has generally not been done, which will be essential for establishing future service and education in sexuality.

Third, continuing attacks by vocal minorities inside and outside of religious bodies has drained energy and commitment from many. New ways of dealing with, or of not dealing with, the "anti(s)" must be found.

And *fourth,* the lack of training and supervision of lay and professional religious leaders in these areas inhibits the development and implementation of good programs. Religious bodies must secure training for their professionals and become better partners with other sexuality professionals.

Nonetheless, to the optimist, the signs of hope are numerous. The inclusion of life experience in the equation of sexual theologizing, and in religious responses to sexuality-related issues, is beginning to lead in new and hopeful directions. As women, racial/ethnic communities, the disabled, and gays/lesbians engage in leadership and in the development of programs that are sensitive to their life experiences, new ways of being together in community are being facilitated.

These perspectives among religious persons hold a potentially enormous benefit for the establishment of more comprehensive, public sexuality education. While increasing religious and cultural pluralism in the United States is experienced by many as threatening, if the concerns outlined in the beginning of this essay are kept in mind, these factors may provide blessings and benefits for public sexuality education. The impact of women, the disabled, and gays/lesbians on religious communities and society, in relation to sexuality concerns over the past 25 years, has been enormous. While AIDS, for example, has paralyzed some with its morbid melding of sexuality and death, others have mobilized in order to create a society where they can live life more fully and honestly. These concerns, coupled with those of all manner of religious persons sensitized to their own creative ways of dealing with sexuality and family, will make forward movement inexorable. Those involved with sexuality education must support and reinforce these positive trends within religious bodies and, in turn, call upon religious individuals and institutions for support in their efforts.

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(Continued on Page 27)

Highlights from Relevant Surveys 1988-1990

Sexuality Education Study

According to a recent study conducted by The Alan Guttmacher Institute (AGI), 93% of junior and senior public high school teachers report that their schools offer sexuality education or AIDS education in some form. Not all topics, however, are taught at every grade level, nor are they covered as early as teachers think they should be. Most believe that a wide range of topics related to the prevention of pregnancy, AIDS, and other sexually transmitted diseases (STDs) should be taught by the end of 7th grade before most teenagers have become sexually active but, in reality, only one-third say instruction is provided by that time. Furthermore, teachers are given relatively little time to devote to sexuality education; on the average, schools offer only six and one-half hours a year on all sexuality education topics; and less than two of those hours focus on contraception and disease prevention.

The biggest obstacle teachers perceive in teaching sexuality education is pressure from parents, community groups, and school officials, especially when covering topics such as condom use, abortion, "safer sex" practices, and homosexuality. Only one-half of those teaching sexuality education feel that parents and the community support their teaching efforts. Eight out of 10 teachers say they need more assistance to teach effectively about prevention of pregnancy and STDs; more than one-half say they need strategies to help them teach these sensitive topics; and at least one-third say they need additional up-to-date, accurate, factual information. Also, most teachers say they need more and better teaching materials because they find state and district curricula inadequate or because they do not have access to these materials.

The majority of states, and large school districts across the United States, support sexuality education in their public schools. All but four states, and almost every large school district, support the provision of AIDS education; support for instruction about STDs and abstinence is nearly as widespread. Yet, only two-thirds of the states, and four-fifths of the districts, require or encourage their schools to teach about pregnancy prevention. Although states have adopted new policies requiring education about AIDS, by-and-large state policies on sexuality education have not significantly changed over at least the last decade since extensive media attention on teenage pregnancy and childbearing issues provided an opportunity to update their sexuality education policies, so that they would better reflect today's issues and concerns.

These are among the more striking findings that have emerged from AGI's study on the status of sexuality education. To determine how sexuality education is presently being taught in the United States, and how teaching corresponds to state and district policies, AGI conducted two surveys in 1988. Across the country, 4,241 public grade school teachers, in grades 7 to 12, from the five specialty areas from which most sexuality education teachers are drawn — biology, health education, home economics, physical education, and school nursing — were surveyed. The teachers were asked questions about themselves and their schools, about their views on whether sexuality education should be taught, and about what topics should be covered and at which grade levels. Those currently providing sexuality education were asked more detailed questions about what they teach. The chief school officer in each of the 50 states, plus the District of Columbia, and the superintendents of each of 162 large school districts in the country were also surveyed to gather information about policies, curricula, and program activities related to the teaching of sexuality education, including what topics states and districts encourage schools to cover and what is done either to establish basic standards or to help local educators develop or strengthen their programs.

According to the Institute's study, the majority of sexuality education teachers are experienced teachers; nearly half have been teaching sexuality education for at least eight years. Only three states, Michigan, Ohio, and Utah, and the District of Columbia, require teachers to complete a course in human sexuality in order to be certified to teach sexuality education, although almost all sexuality education teachers have had some training to teach the subject. Fewer than half of the states, and somewhat more than half of the large school districts, require certification in a specific field, usually health or physical education, in order to teach sexuality education or AIDS education.

The teacher survey revealed that the vast majority of sexuality education teachers cover topics aimed at helping their students avoid unintended pregnancy, AIDS, and other STDs, and present abstinence as the best alternative. However, they are least likely to have covered diseases that have gained prominence more recently, including chlamydia, genital warts, and pelvic inflammatory disease. While most cover birth control methods, one-quarter do so only when students ask specific questions. A majority of teachers also teach about sexual orientation, issues related to abortion, and "safer sex" practices.

Most sexuality education curricula place considerable emphasis on abstinence for preventing both pregnancy and STDs, and virtually all cover the negative consequences of sexual intercourse for teenagers. As with the laws and policies of state education agencies and large school districts, sexuality education curricula tend to focus on anatomy and physiology and give little attention to pregnancy prevention. Only two, out of the 13 state curricula that specifically cover pregnancy prevention, include contraceptive methods and suggest that teachers discuss the risks and benefits of each. Although 97% of teachers surveyed say that sexuality education classes should address where students can obtain birth control methods, not one state curriculum suggests that this information should be provided. And, of 75% of large school districts with sexuality education curricula that deal with the use of contraception, only 41% include information on where to obtain such services.

Public opinion polls show that the majority of Americans support sexuality education because they think it can be effective in decreasing the negative consequences of early sexual activity — more than a million teenage pregnancies occur each year and most are unintentional. Most people believe that students who take sexuality education courses are less likely to become pregnant than those who do not, are more likely to practice birth control if they are sexually active, and are less likely to get a sexually transmitted disease. Past studies on the impact of sexuality education show that it does increase teenagers' knowledge, it may increase their likelihood of using contraception, and it does not encourage them to initiate sexual activity.

The results of the AGI study have been published in two articles in the journal, *Family Planning Perspectives* (March/April, 1989): "Sex Education and AIDS Education in the Schools: What States and Large School Districts Are Doing" by Asta M. Kenney et al, and "What Public School Teachers Teach About Preventing Pregnancy, AIDS and Sexually Transmitted Diseases" by Jacqueline Darroch Forrest and Jane Silverman, and are summarized in the report, *Risk and Responsibility: Teaching Sex Education in America's Schools Today.*

In a *Family Planning Perspectives* editorial, the president of AGI, Jeannie Rosoff, made several recommendations, as a result of the study's findings: "The AGI study points to the need for action at many levels. Teachers on the front line need help, and for a variety of reasons they do not always get it. State and school district sexuality education policies are often vague or overly general — and sometimes even nonexistent. A primary task for state-level policymakers is the development of unambiguous policies on sexuality education and the establishment of detailed curricula. The finding that some states have outdated sexuality education curricula indicates that for effective programming, curricula should be reviewed with some regularity...[which would] ensure that the information conveyed to students is accurate, relevant, and timely. Moreover, teachers must have appropriate materials to use in providing sexuality education. They must not be forced — as the studies show they often are — to develop their own materials because of the limited usefulness or availability of the tools that exist. Finally, teachers need the demonstrated support, not only of their school administrations, but of parents and the community as well...it is active encouragement that is required if secondary schools are to meet the sexuality needs of their students now and in the future."

Comprehensive Health Education Survey

The results of the National Adolescent Student Health Survey (NASHS) — the first national survey done in more than 20 years to determine the behavior, knowledge, and attitudes of our nation's teens on health and sex-related issues — was issued in 1989. The survey, sponsored by the American Alliance for Health, Physical Education, Recreation and Dance/Association for the Advancement of Health Education, the American School Health Association, and the Society for Public Health Education and funded by the U.S. Department of Health and Human Services, indicated that the American public needs to be concerned because American teens are not making proper health decisions. "The results give us fresh insight concerning what our nation's teenagers know and how they act concerning health and sex-related issues — but even when they know better, they don't always make the right health decisions," said Dr. Robert E. Windom, former Assistant Secretary for Health and head of the U.S. Public Health Service. "This up-to-date information should contribute to the improvement of the quality of comprehensive school health education programs. And I believe it also will prove valuable in our efforts to establish new national health goals for the coming years."

The NASHS survey, which questioned more than 11,000 eighth and tenth graders nationwide, revealed startling data on how much teens know about AIDS and other sexually transmitted diseases (STDs); behavior related to violence, suicide and injury prevention; the prevalence of alcohol, drug, and tobacco use; consumer health; and nutrition.

The following are some highlights from the survey:

"Having sex." According to the survey, 62% of male adolescents and 43% of female adolescents believe that "having sex" is acceptable with someone they have dated for a long time; 18% of the males and 4% of the females believe it is acceptable for people their age to have sex with several different people. Adolescents (94% of the females, 76% of the males) also believe it is acceptable to "say no" to having sex.

Sexually transmitted disease. It is estimated that 2.5 million teenagers are infected with STDs each year. Over the next several years, today's teens will be entering the highest risk group (ages 20 to 29) for all types of STDs. Many adolescents do not know how to avoid getting STDs: they do not know (55%) that taking birth control pills is ineffective in avoiding STDs, nor do they know (67%) that washing after sex is ineffective in avoiding STDs. Many also cannot identify common early signs of STDs: 44% do not know or are unsure that a discharge of pus from the sex organs is an early sign of an STD or that experiencing pain when going to the bathroom is an early sign of an STD; 33% do not know or are unsure that a sore on the sex organs is an early sign of STDs.

In addition, more than 38% of adolescents would not know where to go for medical care should they contract an STD, and 49% report that it would be hard for them to pay for treatment; 44% report that they would be embarrassed to ask a doctor what was wrong with them; and 39% report that they do not know an adult they could talk to if they thought they might have an STD. Most mistakenly believe that their parents must be informed in order to obtain treatment for an STD: 76% are unsure or mistakenly believe that the Public Health Department must inform parents about STDs in patients under age 18; 79% are either unsure or mistakenly believe that most clinics must have parental permission to treat patients under age 18 for STDs.

HIV/AIDS. Thousands of adolescents are at risk of contracting the human immunodeficiency virus that causes AIDS because they engage in risky sexual behaviors or drug use, or both. Currently, one-fifth of the people with AIDS are in their 20s; many of whom may have been exposed to the virus are in their teens. Furthermore, many adolescents, regardless of their personal risk, are likely to be affected by the disease by having friends or family members who become infected.

Most adolescents know that there is an increased risk of becoming infected with HIV by having sexual intercourse with someone infected with HIV (94%) or by sharing drug needles; 82% know that there is an increased risk by having more than one partner.

Most adolescents (86%) know that condoms are an effective way to reduce the risk of becoming infected with the virus, and 91% agree that people their age should use condoms if they "have sex."

Many adolescents have misconceptions about AIDS: 71% believe that blood transfusions are a common way to get AIDS today; 47% mistakenly believe that there is an increased risk of AIDS when donating blood; 51% are unsure or mistakenly believe that washing after sex reduces one's chances of being infected with HIV.

Other highlights of the report. *Suicide* is the second leading cause of death for American youth, ages 15 to 24: one out of seven report having attempted suicide; two-thirds report that it would be hard for them to obtain help for a friend who was talking about suicide.

Although other surveys indicate that the *prevalence of alcohol, drug, and tobacco use* with teens has declined in recent years, the NASHS survey reveals that use remains a serious problem with today's teens. The survey revealed that

more than half (51%) of eighth graders and two-thirds (63%) of tenth graders report having tried cigarettes, and 80% of teens reported having tried alcoholic beverages. About one-third reported having five or more drinks on one occasion during the past two weeks.

Unintentional injuries constitute the leading cause of death for young persons ages 15 to 25. The survey found that most adolescents put themselves at risk for injury in automobiles by not wearing seat belts (56%) and by riding in cars when the driver has been drinking (39%). In addition, most of those surveyed, who ride a bicycle or motorcycle, do not wear protective gear.

Adolescents, ages 12 to 19, particularly males, have the highest *victimization rates for crimes of violence.* The NASHS survey revealed that 39% of teens surveyed indicated they had been in a fight in the past year; 34% report that someone threatened or hurt them; 14% reported having been robbed; and 13% report having been attacked while at school or on a school bus, 16% while outside of school. In addition, both boys and girls said that weapons were accessible to them, with nearly one-fourth of the males reporting carrying a knife to school at least once in the past year.

Evangelical Church Teen Sexuality Survey

A teenage sexuality survey of eight evangelical denominations within the United States, "not necessarily representative of all church youth" but believed to be "a fair representation of what has come to be known as the 'fundamental evangelical church.'" has been completed. The eight churches surveyed are: The Church of the Nazarene (number of churches in group, 6,000); Evangelical Covenant Church (650); Church of God (5,700); Free Methodist Church (1,400); Lutheran Church (5,450); Grace Brethren Church (330); The Wesleyan Church (1,600); and The Salvation Army (1,000).

Each denomination selected 12-50 churches, through the use of a multistage probability sample, with stratification based upon size of church youth groups. A four-page survey questionnaire — given to 1,438 young people ages 12 to 18 — was self-administered and all answers were provided anonymously and in confidence. The questionnaire requested information about the teen's relationship with father and mother, lifestyle, self-image, relationships with the opposite sex, sources of sexual information, church activities and religious beliefs, and personal and family background. The term "churched youth" used by the survey referred to the teenage youth the participating evangelical churches considered to be those regularly attending church: 82% of those surveyed stated they attended church each week; 79% are actively involved in the church's youth program; and 82% stated they knew Jesus Christ as their personal Savior. The term "sexual contact" used by the survey referred to fondling breasts, fondling genitals, and/or having sexual intercourse.

The following are some of the findings of the study. Among the respondents, 36% called their home a place where they felt secure and loved, and 59% characterized their home as a place where they either felt uncomfortable or they were comfortable but their family was neither close nor loving. The weaker the respondent's relationship with parents, the greater was the chance of feeling lonely or discouraged, with females more likely than males to suffer from loneliness. Fifty percent of the respondents said they were misunderstood; 38% were lonely; and 39% were discouraged.

The most important variables found to affect a child's self-image were: a close relationship to and spending a lot of time talking with their father; spending a lot of time talking with their mother; feeling secure and loved at home; and a grade average of "A" or "B." However, the survey found that the median amount of time devoted to talking with fathers about things that really mattered to the respondents was less than two minutes per day and with mothers less than four; very little if any of that limited communication was devoted to sexual matters. Only one out of four churched youths said that they talked seriously with their father and only 16% did "special" things with their father on a frequent basis. The survey also found that there was even less meaningful conversation between father and teenager after age 14.

Thirty-nine percent of those who said their parents frequently spent time with them, compared to 61% of those who said their parents seldom or never spent time with them, had experienced sexual contact. By age 13, 20% of the churched youth had engaged in fondling breasts or genitals and/or in sexual intercourse; 53% by the time they reached age 16. Age 14 was a key turning point for a large percentage of young people in terms of sexual attitudes and behavior, the survey noted. "The change of one year apparently brings about a sexual metamorphosis that is far-reaching in its consequences. Much of a youth's attitudes on morality, attitudes about sexual behavior and desires, attitudes toward the family, attitudes toward self are solidified between the ages of 13 and 14."

Three out of 10 churched youth (29%) stated that they would be more likely to have intercourse if they were positive a pregnancy would not result; 28% would be more likely to have intercourse if their parents would not find out; 22% would become sexually active if their parents would not mind; 39% claimed that if they intended to marry an individual, intercourse with that person would be acceptable.

Only 20% of those who had sexual experience were more likely to turn to their parents and to their school for sexuality training. The primary sources of information, about sexuality and sexual relation, for those participating in the survey were: friends, 38%; movies, 26%; parents, 23%; television, 22%; classes at school, 23%; books, 17%; the Bible, 13%; "adult" magazines, 11%; siblings, 10%; and the church, 7%. The churched youth spent an average of 4.9 hours per day, or 34 hours per week, watching television and listening to the radio and/or albums/tapes.

Neither the Bible, nor the training provided by the church, had any apparent relationship with a teen's likelihood of abstaining from sexual contact.

(Continued from Page 24)

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BOOK REVIEWS

PREGNANT TOO SOON: ADOPTION IS AN OPTION
Jeanne Warren Lindsay
Buena Park, California: Morning Glory Press, Revised edition 1988, 224 pp., $15.95, $9.95, teacher's guide $2.

This is the kind of book a counselor would place in the hands of a teen with an unplanned pregnancy who is unsure of what her decision should be and is considering her options. It is short (200 pages), very easy to read (even for a junior high school student), and has well-defined chapter headings. Both the author's use of vocabulary and her style of writing seem well-suited to her audience. She creates a comfortable climate in which to discuss adoption and strongly advises young women to parent by conscious choice, rather than by default. Included in the book are numerous interviews with birth mothers telling their stories, and sample letters from birth mothers to their children and to the adoptive parents.

The issues author Lindsay raises should help pregnant girls, couples, and families go through the process of considering adoption, which is presented as a loving, responsible, and mature choice that ought to be considered as seriously as abortion, parenting, or marriage. The reader is familiarized with terms used in the adoption field, such as "relinquishment," "consent to adopt," and "open adoption"; specific information is provided about California laws and practices up to the date of publication of the book (this is the author's milieu); and both agency and independent adoption are explained and the differences between the two are highlighted. The greatest criticisms about independent adoption are the lack of available counseling and the possibility of unethical practices. The adoptive family for the baby placed independently is not studied by the State Department of Social Services until after the baby is already in the home! In light of the recent negative publicity surrounding the Steinberg case and others, such points are extremely crucial and are handled sensitively in the book. Other topics handled equally as sensitively include fathers' rights, kinship homes, grieving, and releasing older children.

Jeanne Warren Lindsay authored *Pregnant Too Soon* based on 15 years of experience in the Teen Mother Program, an alternative offered to pregnant/parenting students in the ABC Unified School District of Cerrites, California. Readers will benefit from her extensive experience with presenting adoption as an option, as this is an area in which many counselors often lack training or current information, resources, and materials for teens.

This book will be a welcome addition to a counselor's bookshelf — it is a book that can be shared easily with all teenagers who may be facing the critical dilemma of an early, unplanned pregnancy.

Reviewed by Sheryl Roth, CSW, community outreach social worker for Inwood House, New York.

ADOPTION AWARENESS: A GUIDE FOR TEACHERS, COUNSELORS, NURSES AND CARING OTHERS
Jeanne Lindsay & Catherine Monserrat
Buena Park, California: Morning Glory Press, 1988, 224 pp., $15.95, $9.95.

The extreme shifts in what have been perceived as real options for young, unmarried mothers at different times in history are an interesting commentary on social welfare practice and on the issue of women's empowerment. Up until approximately 20 years ago, the vast majority of dependent mothers placed their babies for adoption. Encouraged — and often downright pressured — by families and "helping" professionals, it was commonly felt that no other route could be taken.

Slowly, however, this situation has almost completely turned around. Today, most dependent mothers keep their babies; only 5% relinquish them for adoption. In fact, the option of placing babies for adoption is rarely discussed or is generally rejected as a selfish, uncaring act.

This helpful, readable handbook, however, attempts to redefine adoption as a planful, selfless choice on the part of a young mother. Filled with many good pointers for those working with adolescents and with "older" mothers, *Adoption Awareness* offers guidance for creating a supportive climate in which to counsel these women and delineates the skills and attitudes that are needed to convey the idea that relinquishment of a baby can be a positive and active choice. Various aspects of the adoption picture, including the need to explore resistance to adoption, the importance of family support, and the role of the birth father, are discussed. The authors correctly remind us that awareness of our own attitudes and beliefs is essential if we, as "caring others," are to be true to that description. The engrossing case material scattered throughout the book keep it interesting and true to life, and the call for balanced options — including the choice to parent — is a welcome one.

However, the one glaring problem with *Adoption Awareness* is the omission of abortion as an option. By mentioning abortion, only to immediately dismiss it (the word abortion is not cited in the index), the authors belie their call for a balanced, objective option picture. They also fail to heed their own warning not to let personal biases, such as religious and political beliefs, influence the counseling process. Unfortunately, an adolescent parent still does not have the full panoply of choices that *Adoption Awareness* argues for so intensely. Nonetheless, aside from these troubling factors, Lindsay and Monserrat's work will be a helpful tool as it advocates for sensitive, focused counseling in the often murky, complex field of options counseling for young parents.

Reviewed by Judith T. Milone, CSW, ACSW, director of social work services, Inwood House, New York.

HELPING WOMEN KEEP WELL: A GUIDE TO HEALTH PROMOTION AND ILLNESS PREVENTION FOR THE HEALTH PROFESSIONAL
Richard H. Blum, PhD & W. Leroy Heinrichs, MD, PhD
New York: Irvington Publishers, 1988, 462 pp., $49.50 ($29.50 for *SIECUS Report* subscriber/members who mention this offer in their order).

This textbook by Drs. Blum and Heinrichs, about the health issues of contemporary women, has been written from the perspective of health behaviors and health promotion. Unfortunately, however, like most textbooks in medicine, the book suffers from fairly turgid prose, some unnecessarily awkward phrases (e.g., "self reported felt unwellness prevalence"), and a noticeable absence of human interest detail.

There is an abundance of research citations for every topic, including a variety of psychosocial-behavioral factors in illness and unwellness, obstetrical risks, office-based health promotion activities, and obtaining patient cooperation in securing behavioral change. In addition, the underlying philosophy of making the patient a true partner in her health care, and of taking psychosocial factors into account in diagnosis and treatment, is admirable. The book itself, largely a case for this approach, offers documentation to substantiate its effectiveness, which includes a 64-page bibliography.

This book will be useful for health professionals in classroom teaching — especially physicians with a subspecialty in OB/GYN — but for the educator or counselor, who wants help in going beyond research data and lists of factors for specific interventions and patient-professional contracts for health promotion, the book will offer little assistance for taking action.

Reviewed by Terry Beresford, AASECT-certified sex educator and freelance consultant in family planning.

AUDIOVISUAL REVIEWS

FINDING OUR WAY: MEN TALK ABOUT THEIR SEXUALITY
The Boston Film Cooperative. Produced by Nicolas Kaufman, Mark Lipman, and Cooper Thompson. Video, 1989, 40 mins. Distributed by Newday Films, 853 Broadway, Suite 1210, New York, NY 10003, 212/477-4604. Study guide available. Previewing option. Price: $295 purchase, $60 rental, plus $12 p/h.

Finding Our Way is a videotape that explores how men experience their sexuality. Twelve men gather together in a relaxing atmosphere — a living room packed with overstuffed couches and chairs in a country home — an atmosphere conducive to comfortable exchanges and sharing. They vary in age from 27 to 71, come from different walks of life, and are heterosexual, gay, and bisexual. The men did not know one another before participating in this group experience, however, as they come together to share their concerns and feelings in this setting, the viewer quickly becomes witness to the laughter of recognition and the profound silence of empathy between them.

The older men shed light on the ramifications and the freedom that age brings, and the younger men appear eager for more information. One man expresses his anger, the loneliness he has always felt after having sex, and his frustration at always being the seducer. The oldest man in the group reveals how he came to terms with his homosexuality after 40 years of marriage, what this discovery meant and how his wife responded, and discusses his guilt, fear, and joy. A gay man expresses his desire to be with a woman and to experience his sexuality with a woman who will accept him for who he is. A young married man recounts making love with his wife in a peaceful wooded area, telling the group that she has asked for her ashes be spread in that place upon her death. It was evident to the reviewers after viewing this videotape how little we know about men and their sexuality and how rarely the topic is discussed.

This video — above all else — is so moving. What is truly unique about it is that one so rarely witnesses men in open discussion, much less discussing a topic so intimate as sexuality. It is a credit to both the facilitators, and the men themselves, that such private emotions and experiences could be shared among the group and with those who will be viewing this video. The participants' accounts of pain, discovery, confusion, loneliness, euphoria, and lust — to name just a few — give the viewer a candid peek into the male experience.

Hungry for greater understanding of their sexuality, the men have dealt openly with difficult issues and have created in the process an enlightening discussion. However, the audiovisual review panel concluded that the discussion process might have been more effective if they had concentrated on a few specific themes. So much information was covered that the impact was a bit diluted and the video was a bit too long. Technically speaking the sound was poor, which frequently made the dialogue difficult to understand. Overall, however, this video will be an asset for discussion in a support group and/or in an educational setting.

This video review was written by SIECUS AIDS Associate Carolyn Patierno.

WE BRING A QUILT
The Names Project. PO Box 14573, San Francisco, CA 94114, 415/863-5511, $20.

If I could purchase only one video for a course on HIV prevention, I would buy this one. *We Bring A Quilt* is a 30-minute documentary of the October 1988 showing of the Names Project Quilt in Washington, DC. The video includes scenes of setting up the quilt on the Washington Mall, interviews with friends, families, and lovers of people with AIDS, the candlelight march, and the reading of many of the names. It also includes segments of plays, poems, and songs about people with AIDS.

The video does not deal with HIV, modes of transmission, and means of prevention. Instead, it poignantly focuses on the people who have died from AIDS. The images of the sheer numbers of quilt panels is a dramatic reminder that more than 70,000 people have now died in this epidemic.

I have used this video in training sessions with professionals and in presentations to the general public. Although I have seen it more than a dozen times, each time I am left with an intense feeling that I must do everything I can to prevent this disease from spreading any further.

We Bring a Quilt can be used with all groups, from school children to professionals. I highly recommend it.

This review was written by Debra W. Haffner, executive director of SIECUS.

The members of the ***Audiovisual Review Panels*** *for the reviews included in this issue were: Elizabeth Kaplan, BA, law student; David McAllister, MA, public health educator; Gusta Seidman, SIECUS summer intern/NYU undergraduate; and SIECUS staff members: Diane de Mauro, PhD, director of program services; Elena Deutsch, BA, office manager; Debra Haffner, MPH, executive director; Janet Jamar, BS, director of publications; Carolyn Patierno, BA, AIDS associate; Julie Sperling, BA, independent filmmaker.*

SIECUS Membership Survey

In May 1989, a survey was mailed to all SIECUS members to assist us in developing AIDS education services for our members, to obtain feedback on SIECUS services and publications, and to find out more about our members. We were very pleased with the high rate of response — 32%, or 669 members, responded — as it will be useful in determining the future direction of SIECUS and specific areas that need attention. The following is a summary of the survey's findings.

SIECUS Members

The vast majority of SIECUS members (82%) are employed in a field or profession related to sexuality. The top four professions in which they are involved are:

- 43% Educators
- 13% Psychologists
- 11% Administrators
- 9% Social workers

The fields in which the respondents primarily work are: 24%, college education; 21%, psychotherapy; 13%, health care; 13%, reproductive health; and 13%, high school education.

Among those involved with sexuality education, 57% are teachers, 42% provide professional training, 35% design curricula, 18% evaluate curricula, 11% administer family life education programs, and 4% research program effectiveness.

When members were asked what degrees they hold, they responded:

- 29% MA/MS
- 23% PhD
- 18% BA/BS
- 9% MD
- 7% MSW
- 5% EdD
- 4% RN/LPN

Members were asked to cite the reasons they belong to SIECUS. The following reasons were given (more than one response was permitted):

- 72% To keep informed about the field
- 61% As a professional membership
- 52% To support SIECUS positions and programs

Many of our members have been members for more than seven years:

- 13% Less than one year
- 23% 1-3 years
- 22% 4-6 years
- 16% 7-10 years
- 22% more than 10 years

When asked what other organizations they belong to, in addition to SIECUS, the top six organizations mentioned were: 32%, American Association of Sex Educators, Counselors and Therapists; 25%, National Abortion-Rights Action League; 23%, The Society for the Scientific Study of Sex, Inc.; 20%, National Organization for Women; 12%, American Psychological Association; and 10%, American Public Health Association.

SIECUS Services

The survey asked members what specific SIECUS services were important to their continued membership. Sixty-seven percent said that the *SIECUS Report* was most important; 45%, said bibliographies; 42%, pamphlets; and 31%, library information services.

When asked which SIECUS services and resource materials they had used — and how frequently in the past 12 months — a majority of members had used the *SIECUS Report,* SIECUS pamphlets, and SIECUS bibliographies in the past year.

When asked to rate SIECUS services, respondents rated them as satisfactory or better, with more than one-half (51%) rating services as highly satisfactory. Most of our members are satisfied with services and many feel services have improved over the past year. Ninety-two percent of respondents said that they will renew their membership; the same percentage said they would recommend SIECUS membership to a friend.

The *SIECUS Report*

Ninety-three percent of respondents said that the *SIECUS Report* is helpful, relevant, and an important source of material and resources.

When asked to rate how important particular features of the *SIECUS Report* were to them, the following were rated as very important:

- 74% Articles
- 51% Recommended resources
- 48% Book reviews
- 45% Bibliographies
- 40% Audiovisual reviews
- 38% News & legislative notes
- 38% Editorials
- 23% Conference/seminar calendar

Asked which of the subjects addressed by articles in the *SIECUS Report* have been particularly useful, 69% of respondents said those which focused on AIDS education issues; 65%, adolescent sexuality; 62%, male/female sexuality; 51%, condom use; 48%, pregnancy prevention; 46%, teaching techniques; 45%, sexuality and religious issues; 39%, sexuality education mandates; 31%, sexual abstinence; 29%, government policies/programs; and 19%, building community support.

When asked what aspect of the *SIECUS Report* was most important to them, 69% said new ideas; 44%, resource reviews/listings; 35%, teaching strategies; 23%, program sharing; and, 15%, event announcements.

AIDS Education and Services

As part of SIECUS' AIDS initiative, the survey was designed to elicit baseline data on members involvement in AIDS education. We found that 75% of respondents are providing AIDS education. They are providing it through:

- 39% Speaking engagements
- 31% Individual counseling
- 31% Professional training
- 29% Teaching at the university level
- 22% Health care delivery
- 21% Teaching at the high school level

Forty-eight percent of respondents are using SIECUS services and materials on AIDS: 36% use *SIECUS Report* articles; 29% use the booklet, *How to Talk to Your Children About AIDS;* and 25% use SIECUS' Annotated AIDS bibliographies.

When asked which SIECUS services and publications would be most helpful in providing AIDS education, respondents listed the following categories among their top three choices:

- 37% Publications for adolescents
- 34% Updated bibliographies
- 32% Developing teaching strategies
- 26% Publications for adults
- 25% Evaluating audiovisual material
- 24% Publications for children
- 23% Curricula development/evaluation
- 22% Evaluating written material
- 19% Providing professional training
- 19% Program development
- 10% Building community support

Note: Percentage totals do not always total 100 because not all respondents answered all questions.

SIECUS would like to thank all those who took the time to respond to our survey. Your input has been invaluable.

Conference/Seminar Calendar

SOUTHEASTERN CONFERENCE ON AT-RISK STUDENTS, *February 2-3, 1990.* This first major conference to target at-risk youth will focus on three major topics: preventing and reducing students at risk; reforming and changing educational delivery systems; and facilitating parent involvement in the at-risk program. Among keynote speakers are Dennis Doyle, James Comer, and Elizabeth Murphy. Savannah, Georgia. Contact: Robert C. Morris, Southeastern Conference on Students at Risk, LB 8143, Georgia Southern College, Statesboro, GA 30460-8143, 912/681-5307.

NATIONAL RESOURCE CENTER FOR YOUTH SERVICES ANNOUNCES TRAINING SCHEDULE FOR 1990. Advanced Training Course for Residential Child Care Workers, *February 21-22* (Tulsa, Oklahoma); *May 8-10* (Denver, Colorado); *August 21-23* (Chicago, Illinois); *October 30-November 1* (New Orleans, Louisiana); **Independent Living Seminars, "Preparing Teen Parents for Independent Living,"** *April 3-4* (Chapel Hill, North Carolina); **"Living Arrangement Options for Youth,"** *April 5-6* (Chapel Hill, North Carolina); **"Program Planning and Evaluation,"** *May 1-3* (Jacksonville, Florida); **"Mastering the Intangible Skills: Pass It On!,"** *June 5-7* (Cincinnati, Ohio). Contact: The National Resource Center for Youth Services, 202 W. 8th Street, Tulsa, OK 74119-1419, 918/585-2986, fax 918/592-1841.

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION — ANNUAL MEETING, *February 21-23, 1990.* Mayflower Hotel, Washington, DC. Contact: Penny Bates, 122 C Street NW, #380, Washington, DC 20001, 202/628-3538.

FOURTH NATIONAL FORUM ON AIDS AND CHEMICAL DEPENDENCY, *February 21-24, 1990.* Sponsored by the American Medical Society on Alcoholism and Other Drug Dependencies. Miami, Florida. Contact: American Medical Society on Alcoholism and Other Drug Dependencies, 12 W. 21st Street, New York, NY 10010, 212/206-6770.

SECOND ARAB INTERNATIONAL CONFERENCE ON AIDS, *March 2-6, 1990.* Cairo, Egypt. Contact: Dr. Mohamed Abd el-Aal, Chief Executive, Conference Secretariate, 5 Al Saraya Street, Al Manial, Cairo, Egypt or PO Box 85, Manial el-Roda, Cairo, Egypt, (2)3625042 or 2/3623908, fax 2/3631464.

NATIONAL HISPANIC CONFERENCE ON HEALTH AND HUMAN SERVICES, *March 14-18, 1990.* San Francisco, California. Contact: National Coalition of Hispanic Health and Human Services Organizations, 1030 15th Street NW, Suite 1053, Washington, DC 20005, 202/371-2100.

CONTRACEPTIVE TECHNOLOGY: NEW ISSUES AND OPTIONS IN REPRODUCTIVE HEALTH CARE, *March 9-10, 1990* (Washington, DC) and *March 22-23, 1990* (Anaheim, California). Endorsed by 11 national health and family planning organizations, these conferences "will address the most current and relevant issues faced by providers of family planning services...Assessment and management techniques for common and complex clinical situations as well as the latest information on STDs and contraception will be presented by an experienced faculty specializing in reproductive health care." Textbooks, *Contraceptive Technology, Understanding Your Body* and *Family Planning at Your Fingertips* will be given as resource materials for presentations, for discussions with the authors, and for professional application. Crystal Gateway Marriott, Arlington, Virginia and Disneyland Hotel, Anaheim, California. Contact: Contemporary Forums, 530 La Gonda Way, Suite E, Danville, CA 94526, 415/820-2800.

MONTANA CONFERENCE ON AIDS, *March 22-23, 1990.* Sponsored by the Montana Department of Health and Environmental Sciences. Bozeman, Montana. Contact: Kim Nelson, Montana State University, 318 Montana Hall, Bozeman, MT 59717, 406/944-4930.

THE SOCIETY FOR ADOLESCENT MEDICINE'S 17TH ANNUAL RESEARCH MEETING, "ADOLESCENT HEALTH PROMOTION AND DISEASE PREVENTION," *March 22-25, 1990.* This is the first combined meeting of the Society for Adolescent Medicine and the Society for Research on Adolescence organized in collaboration with the Centers for Disease Control. Open to the membership of both societies. Will include the J. Roswell Gallagher lectures, interdisciplinary symposia, poster and research presentations and special interest group dinners. "Secrets: An AIDS Education Theatre Program for Teens" will be presented as part of a joint reception. Hilton Hotel, Atlanta, Georgia. Contact: Mrs. Edie Moore, Society for Adolescent Medicine, Suite 101, 10727 White Oak Avenue, Granada Hills, CA 91344, 818/368-5996.

15TH ANNUAL SOUTHEASTERN CONFERENCE FOR LESBIANS AND GAY MEN, *March 22-25, 1990.* Raleigh, North Carolina. Contact: Southeastern Conference for Lesbians and Gay Men, PO Box 28863, Raleigh, NC 27611-8863, 919/833-1209.

THE HOPKINS CONFERENCE ON AIDS, *April 1-4, 1990.* This conference, sponsored by the John Hopkins Medical Institutions in celebration of the Centennial of Hopkins Medicine, is designed for professionals involved with patient care or research. Speakers will include: Anthony Fauci, MD, Director of AIDS Research at NIH; Jonathan Mann, MD, Director of the World Health Organization's Special Programme on AIDS; June Osborn, MD, chair, National Commission on AIDS. Baltimore Convention Center and Sheraton Inner Habor Hotel, Baltimore, Maryland. Contact: Jo Martin, 615 N. Wolfe Street, Rm 1605, Baltimore, MD 21205, 301/955-6878.

AIDS: THE CHALLENGE FOR THE COMMUNITY, *April 18-20, 1990.* Cardiff, United Kingdom. Contact: Brian French, Royal College of Nursing of the United Kingdom, 20 Cavendish Square, London W1M 0AB, United Kingdom.

"YOUR CITY'S KIDS," A NATIONAL CONFERENCE ON CHILDREN AND YOUTH, *May 2-4, 1990.* Sponsored by Seattle KidsPlace, The National League of Cities, Washington State Department of Social and Health Services, and Department of Health and Human Services. Will explore "practical programs and policies that make cities attractive, desirable places for children, youth, and families." Workshops will focus on how diverse advocacy groups can join city officials and agencies in developing and implementing successful city programs that will improve urban life for young people. Seattle, Washington. Contact: Richard McConnell, Program Development Chair, 2201 Sixth Avenue, Mailstop 32, Seattle, WA 98121-2500, 206/442-0482.