

# **SIECUS Report**

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## **SEXUALITY EDUCATION: 1994**

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# SEXUALITY EDUCATION FOR COMMUNITIES OF COLOR

M. Joycelyn Elders, M.D.

U.S. Surgeon General

Opposition to human sexuality education for communities of color, and the implications of that opposition, is a subject that is at once very challenging and very frightening for me. The facts about pregnancies and sexually transmitted diseases (STDs) among young people in this country are horrifying:

- In 1990, there were an estimated 1 million teen pregnancies in the United States; one out of ten teenage girls becomes pregnant each year—more than in any other developed country.<sup>1</sup>
- U.S. teenagers have much higher rates of childbearing, abortion, and pregnancy than do adolescents in other developed countries, even where levels of adolescent sexual activity appear to be very similar. In other developed countries, contraceptive services are more widely available, confidential, free, or very inexpensive, and the schools or the media provide realistic and timely information about sexuality and contraception.<sup>2</sup>
- Approximately 2.5 million adolescents have had an STD, and one in four sexually active adolescents will have had an STD before graduating from high school. I shudder to think of what kind of future fertility problems they might face as a result.<sup>3</sup>

The high rate of adolescent pregnancy and of STDs tells us that, even with all the contraceptives available, and all the clinics and all the counseling, and—yes—all of our educational efforts, we still have not provided young women with enough information, access, support, or effective and easy-to-use contraception to maximize their own control over their reproductive lives.

The situation becomes even worse when one concentrates on the impact of adolescent pregnancy on minority youth:

- African Americans are more likely than whites to be sexually active at young ages. By age fifteen, African American males are 2.5 times as likely as white males to have had intercourse. By age fifteen, African American females are twice as likely as white females to have had intercourse.
- After they become sexually active, minority youth

are less likely than their white counterparts to use contraceptives. And, not surprisingly, their pregnancy rates and birthrates are twice as high.<sup>4</sup>

- In 1991, birthrates for African American and Hispanic adolescents were more than twice that for non-Hispanic white adolescents.<sup>5</sup>
- Although the proportion of births to unmarried white teens rose by more than 65 percent during the 1980s, and the proportion to African American teens rose by only 8 percent, African American teens are still almost twice as likely as whites to have an out-of-wedlock birth.<sup>6</sup>

## What Needs to Be Addressed?

We need to convert the evidence on sexuality education into sensible, realistic, workable strategies.

The SIECUS publication *Guidelines for Comprehensive Sexuality Education* capsulizes the problem so well: Over nine in ten parents want their children to have comprehensive sexuality education. Seventeen states require it, and thirty others encourage it. Some eighty national organizations believe that all children and youth should have it. Yet, fewer than 10 percent of children in America receive comprehensive sexuality education. *This has got to change.*

The SIECUS national study *Unfinished Business: A SIECUS Assessment of State Sexuality Education Programs* found that while many states require sexuality education, sexuality information is largely absent from programs in public schools. When I was health commissioner in Arkansas, I devoted much of my energy and efforts to creating an awareness of the problems surrounding teen pregnancy. Once I got people to talk and think about sexuality and the devastating consequences for young people of premature sexual activity, pregnancy, childbirth, and STD infection, we were able to initiate and implement some very effective programs. This is what we need to do on the national level.

As an aside, when I say there ought to be more discussion about sexuality, I mean a number of things.

- I mean that honest, accurate, and sensitive discussion about sexuality helps to educate people

and enable them to talk to each other without embarrassment.

- I mean that in a society in which sexuality can be discussed without embarrassment, parents will be better sexuality educators for their children.
- I mean that being comfortable discussing sexuality makes it easier for clinicians and patients to get to the real issues about contraception, STDs, problems in sexual functioning, and other reproductive health concerns.
- I mean that being comfortable discussing sexuality helps to increase mutual respect and understanding, and ensure that people do not make unwarranted assumptions about what their intended sexual partner wants or does not want to happen.
- And I mean that discussion between partners about sexuality helps to ensure that the needs and concerns of both individuals are made known, and this increases the probability that they will use contraceptives and avoid disease.

So if this is what I mean, why is it that whenever I suggest that we need more discussion about sexuality, certain folks accuse me of promoting pornography and advocating the moral downfall of America? I do not know whether they really feel that way or whether they are just trying to prevent us from doing what needs to be done, so I do not know whether to feel sorry for them or to be angry.

We need to publicize the results of surveys such as the one carried out in 1993 by the World Health Organization Global Programme on AIDS,<sup>7</sup> which found no evidence indicating that sexuality education in schools leads to earlier or increased sexual activity among young people. The study also found that sexuality education is most effective when given before a young person becomes sexually active, and that programs promoting both postponement of intercourse and protected intercourse are more effective than those promoting abstinence alone.

As one recent study pointed out,<sup>8</sup> programs should be more comprehensive. Effective classroom curricula need to be reinforced with schoolwide initiatives such as peer programs, group discussion sessions, individual counseling, theatrical presentations, and media events. Comprehensive programs should also improve linkages with community reproductive health services.

It is my fervent belief that *every child in this country must be a planned, wanted child*. I further believe that all children must also be assured that as they grow up, they will be informed and educated when it comes to matters of sexuality. In order to be more responsive to those in disadvantaged and multicultural situations, we

need to pay better attention to prevention, diversity, accessibility, and communication.

### **Prevention**

We need to "get real." Simply teaching young people to say no does not work. We need to educate our children on how to stay healthy. Risky sexual behavior is often linked with a plethora of other unhealthy sexual behaviors. Adolescents need to know that unprotected intercourse can result not only in an unwanted pregnancy, but also in infection with an STD, including HIV. They need the facts that will help them prevent the serious consequences of risky behavior.

When we consider teenagers raised in poverty—hungry, afraid of the violence and death that stalk the streets, lacking adequate medical care and social supports—we should not be surprised that our messages to say no or use contraceptives do not work. Pregnancy may seem like the least of their worries. In addition to comprehensive health and sexuality education services, we must provide programs that can deliver a range of educational and social services to help them develop a belief in their futures and motivate them to avoid pregnancy.

We need to include in our health education programs community, environmental, and personal health; sexuality; family life; substance abuse; growth and development; nutritional health; prevention and control of disease; safety and prevention of injuries; consumer health; and health education.

### **Diversity**

We need to be more responsive to the growing multicultural populations in this country. We need to eliminate cultural and ethnic barriers in the provision of educational services and develop educational materials that are culturally and ethnically sensitive to clients' needs.

We must have more professionals such as health educators and teachers trained to meet this diversity. We have to start listening more to diverse groups and involve them in the planning, decision making, and design of service delivery systems.

We need to create educational programs that are culturally sensitive, age-appropriate, and available in a range of languages. Printed materials should be at reading levels that are comprehensible and developmentally appropriate for a variety of target audiences, consumers, and client groups.

### **Accessibility**

We need to use education to assure accessibility to services and close the cracks that have allowed adolescents to slip through the system. Providing age-appropriate, sequential health education beginning in early childhood and improving access to integrated health and social services, including access to family planning services for adolescents who are sexually active, are

key steps. We need to help sexually active young people protect themselves against STDs and unintended pregnancies. Programs that build self-esteem and promote self-confidence so youngsters have the skill to say no to premature sexual activity are also vital.

### **Communication**

We need to acknowledge that many children, particularly those in low-income minority groups, do not live in homes where they can be expected to get information regarding sexuality. We cannot change the way a child's parents are, and we cannot change where a child lives, but we can change things at school. We have to improve the way we communicate in our schools. Although many school systems offer sexuality education, only 5 percent of the schools in the United States have comprehensive health education programs.

We need to be more aware that myths about sexuality are perpetuated through peers and that peer influence pervades teenage populations. We must involve families and peers in our educational efforts. Facts need to be presented in a context and in a language that teens understand and respect.

### **Health Care Reform/School-aged Youth Initiative**

There are two components of the president's Health Security Act of which I am especially proud, and that underline my strong belief that we can improve the health of our youth through comprehensive school health education and school-related health services.

While contraception, health education, and access are sufficient for many teenagers, teens who are poor and who live in shattered communities with schools that cannot teach and are not safe need stronger interventions. Therefore, the first part of the initiative provides authority for the development of comprehensive health education programs in the schools. A sequential, age-appropriate, and developmentally appropriate approach to school health education would provide every child with a foundation of knowledge for risk reduction and health-promoting behaviors. Ideally, a comprehensive health education program would take an "all-risk approach," providing information on such topics as growth and development, nutrition, safety, first aid, injury and violence prevention, environmental health, tobacco and other substance abuse, disease prevention and control, mental and emotional health, family life, and sexuality.

The second component of the initiative is a school-based health services effort. School-related health services are logical partners of comprehensive school education in that they can increase access to primary and preventive health care. The plan targets areas with the greatest need, as demonstrated through high rates of poverty, adolescent pregnancy, STDs, HIV infection, substance abuse, community or gang violence, and unemployment. Family planning undoubtedly is, and must be, one of our strongest prevention programs.

### **Conclusion**

Finally, we need to address the increasing attacks by the opponents of comprehensive sexuality education efforts. Fear-based curricula are a disservice to young people. We need to be honest and instill healthy and hopeful messages in our children.

We have to look at these attacks on us and our mission as our opportunity to educate the public about the value of comprehensive sexuality education, and we should never hesitate to express our views. Let us use these attacks, distortions, and outpourings of misinformation as opportunities to present the truth, disseminate accurate data and research findings, and enlist concerned and well-meaning citizens to join in the vitally important mission of preparing our young people to live their lives in a manner that allows sexual communication, control over their own fertility, and protection from coercion and disease.

None of us can afford to be complacent and to assume that we have put out enough information and provided enough education about the many risks that young people face today. We need to continuously provide young people with the opportunities they need to develop lifestyles that incorporate health promotion and disease prevention practices in their daily lives. Only then can we boast that we have done our bit to help them become the productive citizens and healthy adults that they want and deserve to be.

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# SEXUALITY EDUCATION FOR YOUTH IN HIGH-RISK SITUATIONS

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All adolescents face struggles that can put them at risk for a variety of social and health problems. Some, however, have experiences that make them particularly vulnerable to such problems as unintended pregnancy, infection with HIV and other sexually transmitted diseases (STDs), sexual assault, and sexual dysfunction. Youth in high-risk situations include those who are pregnant or parents; have a history of substance use or abuse; have been physically, emotionally, or sexually abused; are homeless, have run away, or have been "thrown away"; are gay, lesbian, bisexual, transgender, or struggling with their sexual orientation; or are incarcerated or institutionalized. Low socioeconomic status, learning disabilities, mental illness, negative peer pressure, antisocial behavior, poor parental modeling, racism, and heterosexism also may contribute to putting adolescents at risk.

Every teenager has different needs regarding sexuality education, reflecting a range of sexual experience and knowledge. Youth in high-risk situations, who often lack the emotional and educational resources they need to avoid the perils of adolescence, may need extra support services, mental health interventions, and guidance. What follows are descriptions of subgroups of youth in high-risk situations based on research or observations I made in six years as a sexuality educator working primarily with these youth. While these categories may foster an understanding of the needs of particular adolescents, it is important to realize that some adolescents will fit into more than one category. In other cases, it may not be quite as obvious that certain adolescents are in a high-risk situation. It is also important to acknowledge that it is the situation that puts the individual at high-risk, and not necessarily anything inherent in the young person.

## Pregnant Teenagers and Adolescent Parents

In the United States, 1 million adolescent women become pregnant each year;<sup>1</sup> approximately half of those pregnancies result in a birth.<sup>2</sup> Early childbearing has an impact on future opportunities for young parents, both male and female. Obtaining child care, health care, further education, and good jobs can be a particular challenge for teenage parents.

Service providers sometimes get so caught up in focusing on the immediate needs of teenagers who are

pregnant or parents that they fail to look at the psychosocial reasons that a particular young woman became pregnant. For example, many of the teenage parents I have worked with have had histories of sexual abuse and substance abuse, which may have contributed to their situations and could greatly affect their futures. Another problem is that more adolescent women than adolescent men become parents each year,<sup>3</sup> reflecting that the sexual partners of adolescent women are often older; negotiating with an older, more experienced partner can put a young woman at a disadvantage when she is trying to practice self-protective behaviors. Programming for pregnant or parenting teenagers should include components for both partners, including information on sexual decision making, pregnancy prevention, pregnancy options, safer sex, sexual abuse, and negotiation skills.

Once teenagers become pregnant or parents, they have even greater needs. The fact that one-third of pregnant teenagers receive inadequate prenatal care<sup>4</sup> makes pregnancy education—including the importance of early prenatal care, and the effects of alcohol and other drugs on pregnancy—critical. Because of the unique constraints that caring for a child can place on young parents, these teenagers need, in addition to sexuality education, support in developing parenting skills and obtaining further vocational training and educational opportunities.

## Substance-abusing Youth

Teenagers who abuse alcohol and other drugs are much more likely than others to drop out of school, have sexual intercourse at a young age, and experience early parenthood.<sup>5</sup> Alcohol and other drugs may lower inhibitions, increase sexual arousal, decrease orgasmic potential and vaginal lubrication, and cause delayed ejaculation and erectile dysfunction.<sup>6</sup> According to one study, drinking even rarely during sexual activity approximately doubles a person's risk for HIV infection.<sup>7</sup> I have worked with teenagers who reported using alcohol and other drugs as "social lubricants," to help them feel more relaxed and outgoing, make contact, and initiate or respond to sexual advances. Adolescents who are struggling with their sexual orientation sometimes use alcohol or other drugs as a way of coping with people's negative reactions to them or

to avoid confronting the issue. Youth dealing with issues of past abuse may use alcohol or other drugs as a means of coping with their feelings of hurt, rage, shame, and betrayal.

Educational messages focusing on social, decision-making, and negotiation skills are critical for these teenagers. Accurate information about sexual orientation, sexual abuse, and the effects of alcohol and other drugs on pregnancy also need to be communicated.

### **Sexually Abused Youth**

Child sexual abuse is alarmingly common. One in four females and one in eight males have a history of childhood sexual abuse.<sup>8</sup> In one study, 74 percent of women who had had intercourse before age fourteen and 60 percent of those who had had intercourse before age fifteen reported having been forced to have sexual relations against their will.<sup>9</sup> Childhood sexual abuse can have a negative effect on later health behavior patterns,<sup>10</sup> perhaps leading to unsafe sexual behavior or drug use. Many of these later behaviors could put people at risk for a host of sexual health problems, including too-early pregnancy and infection with STDs, including HIV. Research is beginning to explore the link between a history of childhood sexual abuse and increased risk for HIV infection.<sup>11</sup> Preliminary results suggest an association between childhood sexual abuse and later difficulty in practicing self-protective behaviors.<sup>12</sup>

Survivors of sexual abuse may have particular educational needs concerning their right to healthy, noncoercive sexuality; setting personal boundaries; intimacy; and gender role identification. Information on safer sex, contraception, sexual assault prevention, and decision-making and negotiation skills also needs to be incorporated into programming.

### **Incarcerated Youth**

In 1992, juvenile courts in the United States processed more than 1.4 million delinquency cases, 20 percent of which resulted in juveniles' being placed in a secure detention facility.<sup>13</sup> Studies indicate that youth who have been incarcerated are likely to become sexually active at an earlier age than other adolescents<sup>14</sup> and experience higher rates of pregnancy<sup>15</sup> and STDs.<sup>16</sup>

Inmate subculture provides adolescents with stereotypical examples of gender roles, valuing strength, dominance, and aggressive behavior while eschewing sensitivity, nurturance, and passiveness. Youth who are incarcerated may feel frustrated by the unavailability of sexual relationships, and feel guilt if they masturbate or engage in homosexual behavior. Youth who have sexual encounters associated with force, fear, or violence while incarcerated may later experience aversion to sexual activity.<sup>17</sup>

These youth need information on the range of sexual expression, how to establish sexual boundaries, con-

traception, and safer sex; they also need opportunities to practice decision-making and negotiation skills. Incarcerated youth with a history of substance abuse, selling or exchanging sex for money or drugs, or sexual offenses will need interventions specific to those issues.

### **Gay, Lesbian, and Bisexual Youth**

The pressures of coping with rejection, isolation, and verbal or physical violence, both in and out of the home, may lead young people who are gay, lesbian, bisexual, transgender, or struggling with their sexual orientation to engage in an array of risky behaviors, including unsafe sexual activity and drug use. Suicide is the leading cause of death among gay, lesbian, bisexual, and transsexual youth.<sup>18</sup> Gay and lesbian young people are 2-3 times as likely as their heterosexual peers to attempt suicide, and they account for approximately 30 percent of all youth suicides.<sup>19</sup> Young people need positive and accurate information about sexual orientation, as well as about safer sex, as it relates to the sexual behaviors they may engage in.

### **Recommendations**

For many young people in the United States, getting accurate, nonbiased information about sexuality is difficult; for youth in high-risk situations, it is even more challenging. Supporting youth in healthy behavior change, and thereby enabling them to delay sexual involvement and avoid high-risk behaviors, is the only way to curb unintended pregnancy and STD/HIV infection. For teenagers engaging in risky behavior, information on risk reduction is vital. Adults often are more resistant to discussing sexuality than teenagers are to hearing about it. Service providers may need to overcome internal resistance to bringing up topics they consider sensitive, as well as discomfort with issues of sexuality; sometimes, providers get blinded by labels such as "high-risk," "hard-to-reach," "troubled," or "problem" youth, and let their fears and biases get in the way of providing much-needed services. Local agencies that provide sexuality education for youth frequently are willing to train staff, as well.

I have found the following strategies helpful in working with all youth, and particularly youth in high-risk situations:

- Avoid making assumptions about teenagers' sexual experience. High-risk teenagers are not necessarily sexually experienced or even knowledgeable about sexuality.
- Avoid being heterosexist. Use language that is inclusive of all youth, regardless of their sexual orientation.
- Set ground rules at the beginning of the program. Establishing clear expectations and boundaries will make for a more comfortable atmosphere.

## **GETTING ASSISTANCE IN WORKING WITH HIGH-RISK YOUTH**

***Professionals who are considering working with youth in high-risk situations or are looking for help can turn to many organizations for information, resources, and training for staff.***

### **Advocates for Youth**

(formerly the Center for Population Options)  
1025 Vermont Avenue, NW, Suite 210  
Washington, DC 20005  
202-347-5700

### **The Alan Guttmacher Institute**

120 Wall Street, 21st floor  
New York, NY 10005  
212-248-1111

### **Children's Aid Society—Bernice and Milton Stern National Training Center for Adolescent Sexuality and Family Life Education**

350 East 88th Street  
New York, NY 10128  
212-876-9716

### **Cities in Schools**

1199 North Fairfax Street, Suite 300  
Alexandria, VA 22314  
703-519-8999

### **Education, Training, and Research (ETR) Associates**

PO Box 1830  
Santa Cruz, CA 95061  
408-438-4060

### **Girls Incorporated**

441 West Michigan Street  
Indianapolis, IN 46202  
317-634-7546

### **Hetrick-Martin Institute for Gay and Lesbian Youth**

2 Astor Place  
New York, NY 10003  
212-674-2400

### **Juvenile Justice Clearinghouse**

Box 6000  
Rockville, MD 20850  
800-638-8736

### **National Advocacy Coalition on Youth and Sexual Orientation**

1025 Vermont Avenue, NW, Suite 200  
Washington, DC 20005  
202-783-4165, ext. 49

### **National AIDS Clearinghouse**

PO Box 6003  
Rockville, MD 20849-60003  
800-458-5231

### **National Association of Community Health Centers**

1330 New Hampshire Avenue, NW, Suite 122  
Washington, DC 20036  
202-659-8008

### **National Clearinghouse for Alcohol and Drug Information**

PO Box 2345  
Rockville, MD 20847-2345  
800-729-6686

### **National Coalition of Advocates for Students**

100 Boylston Street, Suite 737  
Boston, MA 02116  
617-357-8507

### **National Information Center for Children and Youth with Disabilities**

PO Box 1492  
Washington, DC 20013  
800-695-0285

### **National Network of Runaway and Youth Services**

1319 F Street, NW, Suite 401  
Washington, DC 20004  
202-783-7949

### **National Organization on Adolescent Pregnancy, Parenting, and Prevention**

4421A East West Highway  
Bethesda, MD 20814  
301-913-0378

### **National Resource Center for Youth Services**

202 West Eighth  
Tulsa, OK 74119  
918-585-2986

### **Planned Parenthood Federation of America**

810 Seventh Avenue  
New York, NY 10019  
212-541-7800

### **Sexuality Information and Education Council of the United States**

130 West 42nd Street, Suite 2500  
New York, NY 10036  
212-819-9770

### **YWCA of the U.S.A.**

726 Broadway  
New York, NY 10003  
212-614-2844

- Model a positive approach to sexuality education. Many teenagers have never discussed sexuality openly and honestly with an adult. If they sense that the facilitator is uncomfortable with the information, they will be, as well.
- Convey that sexuality is a natural and healthy part of living. For youth who have had nonconsensual or otherwise negative sexual experiences, that may be a difficult concept to accept.
- Actively involve youth in program planning, and be flexible in responding to the needs of various groups.
- Be prepared to adapt activities for youth with limited verbal or writing skills, or with short attention spans.
- Because youth learn just as much from each other as they do from adults, incorporate peer group interaction into services.
- Recognize your values concerning sexuality, and help youth to explore their own ethical, spiritual, and moral concerns, as well as group and cultural variations.
- Learn from successful programs. See page 6 for a list of agencies that work with youth in high-risk situations, and communicate with them.

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# **SEXUALLY TRANSMITTED DISEASES AND STREET YOUTH: Rates and Interventions at a Clinic in New York City**

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**C**hildren, adolescents, and young adults throughout the world find themselves surviving the streets alone for numerous reasons. Some such "street youth" have been abandoned, asked to leave home, thrown out, neglected, or abused (physically, sexually, or emotionally); others have left of their own accord because of the dysfunction within whatever system they were a part of—primarily the family or the social service system. Worldwide, the population of street youth is estimated to be at least 100 million.<sup>1</sup> In the United States, street youth numbered approximately 1.3 million in 1982,<sup>2</sup> and 1.5 million in 1992.<sup>3</sup>

Youth living on the streets engage in various kinds of sexual intercourse for differing reasons: "survival" intercourse, the bartering of sexual relations for money, food, clothing, shelter, drugs, or any other needed commodity; "abusive" intercourse, including rape, incest, sodomy, and other nonconsensual sexual acts; "recreational" intercourse, or consensual sexual relations engaged in primarily or exclusively for enjoyment; and "comfort" intercourse, involving sexual intimacy between persons in need of immediate comfort, affection, and human contact (common in prison).<sup>4</sup> In one study of street youth in the United States, 60 percent reported a history of sexual abuse;<sup>5</sup> at a counseling project for street youth in New York City, nearly 90 percent of males receiving services each month report engaging in survival intercourse.<sup>6</sup>

In view of these circumstances, it is not surprising that street youth have dramatically higher rates of infection with sexually transmitted diseases (STDs), including HIV, than youth not living on the streets or the general population of same-aged youth. Overall, 17 percent of sexually active adolescents in the United States have an STD.<sup>7</sup> Yet, STD rates in studies of street youth range between 50 percent and 71 percent.<sup>8</sup>

Prevalence of HIV (acquired primarily through sexual intercourse) is also higher among street youth than among their domiciled peers: Some 5-6 percent of

those tested for HIV at a shelter for homeless youth in New York City were found to be infected,<sup>9</sup> compared with fewer than 1 percent at nineteen U.S. universities.<sup>10</sup> Although it is estimated that only 1 percent of persons with AIDS are adolescents,<sup>11</sup> more than 20 percent of persons with AIDS are in their twenties, and a majority of these are thought to have been infected as adolescents.<sup>12</sup>

Additionally, sexually active gay and bisexual male youth have higher rates of HIV and STD infection than other youth in general. For example, among young men identifying themselves as gay or bisexual, rates of 26 percent and 5 percent have been found, respectively, at a shelter for youth in New York City and at a college in Maryland.<sup>13</sup> In another study, gay males aged 20-24 seen in STD clinics nationally had an STD rate of 30 percent, yet the rate for all persons in that age range was only about 1 percent.<sup>14</sup> This is of particular concern because roughly one-quarter of gay and lesbian youth are forced to leave home as a result of their family's intolerance of their sexual orientation,<sup>15</sup> and 25-40 percent of street youth identify as gay, lesbian, or bisexual.<sup>16</sup>

Despite the incidence of STDs, including HIV, among street youth, these young people are unlikely to seek medical care at traditional health care facilities. Because of the discrimination they often face when they do so, many street youth prefer to remain on the street without receiving appropriate health services. It is therefore essential that programs be established that allow youth to get the care they need in a nonthreatening environment. One such program is SafeSpace.

## **SafeSpace**

SafeSpace is a comprehensive day program for street youth that operates under the auspices of The Center for Children and Families in the Times Square area of New York City. The youth it serves—who are lesbian, gay, bisexual, transgender, and straight—validate the findings outlined above. SafeSpace engages young peo-

ple through street outreach staff and trained peer educators; it also accepts referrals from agencies such as other street outreach programs, hospitals, clinics, courts, and shelters. The program's approach is proactive and is aimed at educating youth about risk reduction and well-being.

SafeSpace offers youth access to showers, laundry facilities, clothing, and meals. It also provides HIV education and prevention services; mental health and medical services, including HIV primary care; crisis intervention; case management; peer counseling and education; acupuncture for substance detoxification and stress reduction; training in independent living skills; GED training; legal assistance and advocacy; recreational activities; computer and writing workshops; and support groups. SafeSpace serves more than five hundred youth annually. Approximately 90 percent of these young people are members of racial or ethnic minority groups; 55 percent identify as gay, lesbian, bisexual, or transgender.

***"It is ... essential that programs be established that allow youth to get the care they need in a nonthreatening environment."***

Youth participating in the SafeSpace program have the option of seeing a health care provider, but they are not required to do so. Clinic staff explain all health-related services and findings to youth, to enable them to make informed decisions about their care, and support them in their decisions. No test, treatment, or procedure is done without the consent of the youth. Staff encourage all youth to undergo a complete medical and psychosocial history; blood work including syphilis serology and a screen for hepatitis B virus (HBV); gonorrhea and chlamydia screenings; and a Pap smear for female clients.

Between March 1993 and June 1994, 139 clients aged 14-25 were screened for at least one STD at the SafeSpace medical clinic. Staff took sixty-five cultures for the assessment of gonorrhea, chlamydia, trichomoniasis, or bacterial vaginosis. Twenty-three of those cultures (35 percent) were positive for at least one infection: fourteen for gonorrhea, six for chlamydia, one for trichomoniasis, and two for bacterial vaginosis. Of 104 youth screened for syphilis, eight (8 percent) tested positive.

Ninety-one SafeSpace clients were tested for HBV, and thirty-seven (41 percent) had laboratory results indicative of either infection (twenty-four, or 26 percent of those tested) or vaccination (thirteen). Those who

were infected most likely had contracted the virus through sexual intercourse, and four of these young people were HBV surface-antigen-positive, which means they could transmit the virus to others.

Of the 139 clients assessed, twenty-seven (19 percent) were HIV-infected. Twenty-one youth were tested for HIV for the first time at SafeSpace; two of these were infected. It must be noted that since HIV testing at SafeSpace is not mandatory, many high-risk individuals decline to be tested; hence, these rates of HIV infection are a low estimate for this population.

STD screenings also revealed three cases each of herpes simplex virus and human papilloma virus (HPV), and two cases of hepatitis C virus (HCV); one youth had three intestinal parasitic infections, which were most likely secondary to unprotected oral-anal intercourse.

Among the 139 clients assessed for STDs, fifty-six (40 percent) tested positive for at least one infection. (Some had more than one infection; hence, the number of infections diagnosed exceeds 139.) Even when HIV is excluded as an STD, the number remains high—forty-four (32 percent). The majority of youth with treatable STDs diagnosed at SafeSpace received treatment through the program; a few did not return for treatment.

Clients seem to feel comfortable getting medical care at SafeSpace because the care is incorporated into the larger program in a nonthreatening, nonjudgmental manner, and because the health care providers at SafeSpace give youth the information they need to make decisions that most benefit them. In addition, once providers have established trusting relationships with clients, the youth often return to the clinic with physical complaints that are found to be the expression of larger psychosocial problems. Hence, SafeSpace is able both to empower youth to make informed health care decisions and to provide them with comprehensive health services.

### **Conclusion**

The vast majority of street youth are disconnected from most mainstream medical facilities—some because of discrimination stemming from homophobia, sexism, classism, and fear on the part of traditional medical and social service providers; others because of these same providers' lack of knowledge about street youth or unwillingness to care for them. The demand for programs such as SafeSpace increases dramatically each year for these reasons.

Street youth are at extremely high risk of violence and harm, and those who identify as gay, lesbian, or transgender are at even greater risk. Among these disenfranchised populations, STDs are a silent killer.

Programs that are easily accessible, nonsectarian, non-judgmental, and focused on harm reduction are key to keeping these young people alive and safe, as well as preventing the further spread of STDs.

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## UPCOMING CONFERENCES

### AFRICAN AMERICAN WOMEN'S HEALTH CARE SUMMIT: Impact of Health Care Reform

The U.S. Public Health Service is sponsoring a health care summit to examine emerging policies affecting the delivery of health services in African American communities. The summit will take place at the Sheraton Seattle Hotel and Towers, September 26-27, 1994. Educational credits will be offered.

For more information, call James Bowman Associates, 206-223-0128.

### INTERNATIONAL CONGRESS ON CROSS-DRESSING, GENDER AND SEX

The International Congress on Cross-dressing, Gender and Sex, which is being sponsored by a number of organizations in the scholarly and cross-dressing community, will take place in Los Angeles on February 23-26, 1995. Papers are invited on transvestism, transsexualism, and all aspects of nonconforming gender expression, and are expected to reflect wide-ranging viewpoints on current research concerning biological, psychological, sociological, cultural, and historical aspects of gender crossing.

Individuals interested in participating should submit four copies of an abstract of no more than 500 words; authors' names and contact information should appear on a separate page attached to the first copy of the abstract. *Deadline for submissions is October 1, 1994.*

Send abstracts or requests for information to Professor Vern L. Bullough, 17434 Mayall Street, Northridge, CA 91325; phone 818-885-0869; fax 818-885-5561.

# ATTACKS ON PUBLIC SCHOOL SEXUALITY EDUCATION PROGRAMS: 1993-94 School Year

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Since 1989, despite widespread public support for sexuality education in the public schools, tremendous controversies have arisen in communities throughout the United States over the content of sexuality education courses. The underpinnings of these controversies lie with the shift in position taken by the radical right, who once opposed any teaching of sexuality-related issues in the schools. During the late 1960s, organizations such as the Christian Crusade published booklets with titles like *Is the Little Red Schoolhouse the Place to Teach Raw Sex?* and argued that parents were the only appropriate source for information about sexuality.

In the mid-1980s, the radical right position on sexuality education changed. The radical right began to embrace the concept of public school involvement in sexuality education, but demanded that programs exclude critical information on topics including contraception and prevention of sexually transmitted diseases (STDs). At the same time, the federal government, under Title XX, the Adolescent Family Life Act (AFLA), made approximately \$7 million available annually for the development of "family centered" pregnancy prevention programs emphasizing abstinence and adoption. Numerous conservative organizations, including many with religious affiliations, applied for grants. Programs such as *Sex Respect*, *Facing Reality*, and curricula developed by Teen Aid, Inc. (*Me, My World, My Future; Sexuality, Commitment and Family*), received their original funding under AFLA.

The federal government was sued for providing public funding to programs that promoted specific religious teachings. The case, *Chan Kendrick et al. v. Dr. Louis Sullivan, Secretary of the Department of Health and Human Services*, was settled out of court after the election of President Bill Clinton. The terms of the settlement include a requirement that funded programs be free of religious teachings and be medically accurate. In June 1994, the House of Representatives considered shifting the monies previously available under Title XX

to programs providing education to adolescents about a range of health issues, including violence, HIV/AIDS, pregnancy, and drug and alcohol use. But an outcry by conservatives in favor of the abstinence-only programs led the House to reappropriate the funding for Title XX. The Senate has not yet taken up the debate over Title XX funding.

Radical right organizations and companies that publish abstinence-only, fear-based materials have promoted their approach to sexuality education throughout the country. This influence has been felt nationally as well as at the state and local levels. At the national level, an amendment to the Elementary and Secondary Education Act introduced by Representative Jon Doolittle (R-CA) would have required that public school sexuality education programs meet ten criteria, including "stressing abstinence" and promoting heterosexual marriage. The House defeated the amendment in late March, and the Senate will likely revisit it during the summer of 1994.

Numerous state-level controversies have affected policy both legislatively and through state school boards. For example, state legislators in New Jersey, Kansas, and Georgia have introduced legislation that would require all family life education to "stress abstinence" and to emphasize that premarital sexual behavior is unhealthy and inappropriate. In Texas, adoption of new health textbooks incited widespread debate when conservative members of the state board of education objected to a wide range of information. These board members and their supporters pressed for the removal of phone numbers for organizations providing information on sexuality and sexual orientation, and even objected to the inclusion of pictures to educate students about performing breast and testicular self-examinations. The outcomes of such developments have an impact on the rest of the nation, as publishers often market materials developed for Texas to the rest of the nation.

However, the battles that will have the greatest

impact on what children and youth are taught occur at the local level. In most cases, local school boards determine which curricula will be implemented, and these boards have faced increasing pressure from local conservative groups, some of which are affiliated with or receive support from national radical right organizations. Fundamentalist churches and conservative taxpayer groups often join in opposing a comprehensive approach to sexuality education. Sexuality education is also used as a wedge issue: once people are mobilized to fight against comprehensive sexuality education, they may also be enlisted to fight against self-esteem or Head Start programs, or to advocate for teaching creationism or instituting school prayer. The attack on public school sexuality education is only one element of a much broader set of challenges to public school education.

### 1993-94 School Year Trends

SIECUS has been monitoring local controversies over sexuality education since the 1991-92 school year. The number of controversies during the 1993-94 school year—more than one hundred—exceeded that in either prior year and brought the three-year total to over 250 in forty-three states. As in the past, these conflicts were not restricted to any particular state or region. Significant trends include the following:

- Despite evidence to the contrary,<sup>1</sup> television, radio, and print media have embraced the idea that a “virginity trend” is sweeping the nation (see fact sheet on pages 21-22). This media attention has helped fuel the nationwide debate over how much emphasis to place on abstinence.
- In communities that do not seem amenable to a fear-based curriculum, those opposed to comprehensive sexuality education have begun to propose running two parallel programs—one fear-based program and one more comprehensive program. This option has been rejected by most communities in which it has been attempted. Many districts are concerned about the costs associated with running two tracks for sexuality education classes, and about the precedent it could set: the same groups that favor fear-based education classes might, for example, also push for separate literature or social studies classes.
- In some cases, opposition groups have attempted to get districts to replace “opt-out” policies with “opt-in” alternatives. In other words, parents or guardians currently have the right to remove their children from sexuality education, or opt out. But these opposition groups, realizing that requiring parental consent for children to attend sexuality education classes could represent a formidable barrier, have pushed for such opt-in approaches in numerous districts.

- Arguments that students should be separated by gender for sexuality education courses are increasing, especially at the elementary level. Few data exist on the effectiveness of this approach. The resources required to provide separate classes create a difficult burden for schools. Separating students by gender when discussing certain topics may have both costs and benefits; however, this conflict must not preclude teaching any sexuality information whatsoever.

The typical scenario for a community controversy has remained the debate about whether or not to replace an existing sexuality education program with a fear-based one. Most school programs already emphasize abstinence. In a 1993 survey that evaluated twenty-eight state-level sexuality education curricula in-depth,<sup>2</sup> SIECUS found that twenty-seven cover abstinence. (The exception is an elementary school curriculum.) The topics least likely to be covered include sexual orientation, abortion, masturbation, shared sexual behavior, and human sexual response. Only ten states each at the junior and the senior high school levels address contraception.

### Community Controversies<sup>3</sup>

The following is a sampling of the controversies that SIECUS identified during the last school year.

**Hemet, California.** A controversy that began early in 1993 over the teaching of *Sex Respect*, a fear-based curriculum, in Acacia Middle School continued during the 1993-94 school year. A parent had filed a complaint in March 1993 alleging that the curriculum, which the local school district had used since 1989, contains medical inaccuracies and sectarian doctrine and therefore violates the state education code.

The board of trustees, with four conservative and three moderate members, approved a new districtwide sexuality education policy in February 1994. The new policy includes teaching that sexual behavior outside marriage is irresponsible, and inviting prolife organizations into schools each time an organization that is considered prochoice, such as Planned Parenthood, is invited to speak on any topic.

A community group called the Interfaith Community Alliance is leading the effort to get *Sex Respect* removed from the public schools. A committee of teachers recommended that for the 1994-95 school year, *Sex Respect* be discontinued and a new health education course be adopted. The district has yet to make a final decision.

The controversy is likely to continue and to become more heated. In April 1994, after the state attorney general's office refused a request by the school district to issue an opinion on the legality of the *Sex Respect* curriculum, the state education department began its own investigation into the sexuality education curriculum at Acacia Middle School; this investigation is ongoing.

Some community members are interested in bringing a lawsuit against the school board on the grounds that *Sex Respect* violates California law.

**Simi Valley, California.** Early in the school year, a controversy developed over whether to add information about contraceptive methods to the sexuality education curriculum for junior and senior high school students, as a community task force had recommended. A majority of board members support the recommendations of the task force, as do a large group of students, who have formed the Alliance for Student Empowerment. Opposed to the expansion of the curriculum, which stresses abstinence, but includes other topics, are some parents and a small group of students who believe that abstinence is the only contraceptive method that should be addressed in school.

In February 1994, the school board unanimously approved the new sexuality education policy; school officials must now use the approved guidelines to write a new curriculum, to be implemented in the 1994-95 school year.

Those who want an abstinence-only curriculum are now pushing for the fear-based program *Choosing the Best*, which includes the film *Sex, Lies, and the Truth*, produced by Focus on the Family (see review on page 25). The program also includes a slide presentation that contains inaccurate information about condoms, STDs, and HIV/AIDS. The controversy is likely to continue during the next school year.

**Vista, California.** A controversy over sexuality education in the middle schools, which has received national media attention, continues. At issue are the replacement of Vista's abstinence-based curriculum, *Values and Choices*, with *Sex Respect*, and a proposed policy to ban discussions on certain sexuality-related issues.

The school board, composed of three conservative members and two moderates, voted to replace *Values and Choices* with *Sex Respect*, although the majority of community members who attended the board's meeting on the topic testified on behalf of *Values and Choices*. The school board's attorney claims that with some minor changes, *Sex Respect*—which contains religious undertones, racial and gender bias, and inaccurate and misleading information—could comply with California law. Community members are likely to file litigation against the school board when Vista begins teaching *Sex Respect* in the fall of 1994.

The board also approved a proposal to limit discussions on masturbation, homosexuality, and contraception. Under this policy, teachers would be permitted to discuss birth control only in eleventh- and twelfth-grade classes, and only in the context of marriage. They would not be allowed to discuss homosexuality or masturbation unless a parent requested them to do so. Meanwhile, a movement by a parents group called

the Coalition for Mainstream Education to recall two of the conservative board members continues.

**Jefferson County, Colorado.** Controversy developed in January 1994 over a sexuality education course the county school board planned to offer as an elective to eighth graders; the course would have included information on abstinence and other contraceptive methods. Opponents of the curriculum wanted the board to offer an abstinence-only curriculum or to provide such a course as an alternative to the one proposed. The board unanimously approved the new sexuality education program, only to have a school board election result in the replacement of two moderate board members by two conservatives. The controversy continued as the new board members attempted to have the curriculum further restricted.

The school board voted again, and the moderate majority succeeded in getting the course passed. The new elective course began in January 1994; it will be evaluated after each of the next three years.

**Lake County, Florida.** School board members want to have the human growth and development curriculum reexamined to ensure that it is abstinence-based, according to state law. The vice-chair of the board spearheaded the effort in 1993 to have each chapter of the curriculum reexamined.

At the center of the controversy are chapters containing information on topics such as masturbation, sexual response, abstinence, abortion, and STDs. The schools superintendent maintains that the curriculum is abstinence-based.

The school board discontinued an adaptation of the curriculum to be used for developmentally challenged students, calling it too sexually graphic. The vote was 3-1, and the board acted without previewing the program for parents. In addition, school board members appointed a new committee in January 1994 to study the issue further. There were complaints about the removal of the program before parental review, and citizens on both sides of the issue criticized the committee appointment process as "Machiavellian."

The controversy over the use of the curriculum in the district at large is ongoing.

**Peoria, Illinois.** District 150 wrote a new comprehensive sexuality education curriculum in October 1993 to replace one that included no information on contraception. The board updated information and added new topics. Some parents and church groups, however, are not satisfied with the new curriculum.

The Parent Information Network, a group of roughly forty parents who oppose the new curriculum, contends that it does not adequately stress abstinence and gives too much information to children before seventh grade. The opposition is also promoting fear-based curricula.

Proponents of the more comprehensive program claim that because parents can choose to remove their children from all or some of the classes, those who oppose the curriculum are attempting to impose their views on others.

The school board voted to implement the comprehensive sexuality education curriculum. A pilot program was implemented in February 1994, and the curriculum should be in place districtwide in the fall of 1994. The new program has a lot of support in the community, and the controversy seems to have subsided for the time being.

**Shreveport, Louisiana.** The Caddo Parish School Board adopted *Sex Respect* and *Facing Reality* as its sexuality education curricula in November 1992. Shortly thereafter, a group of parents and other residents filed a lawsuit to keep both programs out of the classroom.

In March 1993, a judge ruled that portions of *Sex Respect* and *Facing Reality* violate Louisiana law by including subjective religious and moral beliefs, inaccurate medical information, opinions on abortion, and quizzes about students' personal values. The school board appealed the decision and implemented the program after deleting some of the material that the judge had ruled violated state law. An appeals court upheld nearly all of the ruling on illegal portions of the curricula. The school board is considering appealing to the state supreme court.

**Framingham, Massachusetts.** After students petitioned the local school committee (as school boards are known in Massachusetts) for more sexuality education, a pilot comprehensive sexuality education curriculum for all students was developed. A fractious debate followed over the scope of information that would be taught in the classroom. Conservatives in the community opposed the pilot program.

In April 1993, three conservatives who strongly criticized the proposed sexuality education program lost their bids for school committee seats. The pilot program was accepted by a 4–3 committee vote and was implemented in the spring of 1993. Framingham school officials believe the pilot program was a success; only two of 1,133 students opted out of the course. Thus, the sexuality education was implemented in 1993–94 for its first full school year.

**Newton, Massachusetts.** A heated debate that had begun during the 1992–93 school year over the development of a comprehensive health and sexuality education program for grades K–12 continued. A group called the Newton Citizens for Public Education (NCPE) formed to oppose the proposed curriculum. In school committee elections in November, however, supporters of comprehensive sexuality education defeated NCPE candidates. Some of the proponents have formed the

Lighthouse Institute for Public Policy, an organization that details efforts by national radical right organizations to influence school board elections. In addition, the local Planned Parenthood affiliate spearheaded the formation of a Newton group called PURPOSE, Parents United for Responsible Policies on Sexuality Education, whose main objective is to help parents maintain comprehensive sexuality education in the public schools.

The ninth-grade pilot curriculum was passed, and the curriculum will likely be implemented in grades K–12. Although the NCPE continues to oppose the curriculum, this battle seems to be over for the time being.

**Braintree, Massachusetts.** Controversy developed over the HIV/AIDS curriculum being drafted for local schools. In June 1993, the school committee voted 4–3 against implementing the proposed health and human sexuality curriculum for grades K–12 and threw out the HIV/AIDS program.

A conservative group called Concerned Parents and Citizens of Braintree claimed that the proposed curriculum was aimed at children who were too young and that it failed to promote abstinence as the only sure way to avoid HIV/AIDS. In response, supporters of comprehensive sexuality education formed the Community Advocates for Responsible Education. Concerned Parents argued that teaching students about condoms encourages them to have intercourse and pressed for the fear-based program *Free Teens*, while the Community Advocates support a curriculum that stresses abstinence and provides information on condoms.

The school committee voted 5–2 to have a group of professional educators devise an HIV/AIDS lesson plan for ninth graders. The controversy is likely to continue during the development of the new HIV/AIDS curriculum and upcoming school committee elections.

**West Windsor–Plainsboro, New Jersey.** In June 1993, the school board approved *Learning about Family Life*, a K–12 comprehensive sexuality education curriculum. Opponents of the curriculum believe that it is not age-appropriate because it teaches children the correct terminology for all body parts, including the genitalia. A group of parents and teachers reviewed it and decided what portions should be used.

The controversy over the program received widespread attention in the community, which led to a school board meeting attended by 250 people, many of whom offered comments regarding the adoption of the curriculum. By January 1994, the district had decided to use only fourteen of the forty-three chapters of the curriculum, and had omitted controversial passages. This, however, did not appease opponents, and 200 of the 2,100 children in grades K–3 were removed by their parents from some or all of the course.

It seems this controversy is over for now. The

## RESOURCES FOR SUPPORTING COMPREHENSIVE SEXUALITY EDUCATION

*The following resources may be useful in crafting effective strategies for supporting comprehensive sexuality education programming:*

- The SIECUS Community Action Kit includes an array of information on ways to promote comprehensive approaches to sexuality education and the shortcomings of fear-based approaches. The kit can be obtained for \$29.95 by writing to SIECUS Publications, 130 West 42nd Street, Suite 2500, New York, NY 10036.
- The National Coalition to Support Sexuality Education consists of over eighty mainstream organizations that support the provision of comprehensive sexuality education to all children and youth by the year 2000. For a fact sheet about the Coalition, send a self-addressed, stamped envelope to SIECUS Publications.
- A World Health Organization review of studies done both in the United States and abroad shows that the vast majority of research confirms the effectiveness of sexuality education in influencing young people to delay the initiation of intercourse and helping those who become sexually active to use contraception.
- A coalition of more than sixty national and local organizations has produced *How to Win: A Practical Guide to Defeating the Radical Right in Your Community*, a manual covering a wide range of topics, from organizing broad-based coalitions to delivering an effective speech. The manual is available for \$25 from the National Jewish Democratic Council, 711 Second Street, NE, Suite 100, Washington, DC 20002.
- People For the American Way has published a report that examines the connection between the radical right and the abstinence-only, fear-based education movement. A copy of this report, *Teaching Fear: The Religious Right's Campaign against Sexuality Education*, can be obtained for \$5.95 from People For the American Way, 2000 M Street, NW, Suite 400, Washington, DC 20036.
- *Challenging the Christian Right: The Activist's Handbook*, published by the Institute for First Amendment Studies, provides comprehensive background on the radical right, including history, tactics, major groups, and strategies for effectively countering the right on a wide range of issues. The handbook is available for \$28.50 from the Institute for First Amendment Studies, PO Box 589, Great Barrington, MA, 01230. Also available from the Institute, for \$7.95 plus postage and handling, is *The Religious Right: The Assault on Tolerance and Pluralism in America*.
- For keeping up on radical right activities and arguments, consider ordering materials directly from far right organizations. This may require sending a small donation so that you will receive fund-raising mailings, notices about new materials, and, in some cases, newsletters and magazines.

watered-down curriculum remains in place, and parents are exercising their right to remove children from any part of the course they deem inappropriate.

**Memphis, Tennessee.** Parents and school board members clashed over an April 1994 study that recommended continuing the district's comprehensive family life curriculum and strengthening it by using specially trained instructors. The curriculum teaches children about families, human sexuality, and other issues. Some parents feel it is too "nondirective" and want it to state that sexual behavior outside marriage is wrong. Opponents also want an abstinence-only curriculum offered as an alternative.

The family life curriculum study was commissioned by the school board under a state requirement. Its recommendations included modifying the program to incorporate special training on resisting peer pressure,

a greater emphasis on abstinence, and new techniques to involve parents. It also recommended that the modified program be conducted on an experimental basis at two schools and be evaluated after one year.

The recommendations of the study have yet to be implemented, and the controversy is not yet over.

**Lake Washington, Washington.** A battle erupted in December 1993 over the use of the video *Considering Condoms* in the public schools. Opponents of a comprehensive approach have formed the Concerned Parents Coalition, filed a request that the board reconsider the issue, and threatened litigation. They argue that the video sanctions teenage sexual behavior and minimizes the failure rates of condoms. Proponents claim that abstinence is mentioned fifteen times in the video and that the video is a small part of a sexuality education program that already stresses abstinence.

They also point out that viewing the video is optional: parents who do not want their children to watch it may choose for them to see a film with an abstinence-only message or opt out of both. The majority of parents have elected to have their children view the video.

In early spring, the school board reaffirmed its decision to allow the video to remain in school. The controversy is likely to continue, however, as the Concerned Parents Coalition has vowed to pursue legal action if necessary.

**Oconto, Wisconsin.** Controversy developed late in 1993 over whether the local school board should adopt an abstinence-only or an abstinence-based sexuality education curriculum. The abstinence-based curriculum has been taught in the district for the past several years. The state education department requires that school districts appoint a human growth and development committee to reevaluate their programs every three years. The committee, made up of parents, teachers, clergy, and school administrators, recommended an abstinence-only program to the school board in 1994. Proponents of the existing program argued that a comprehensive approach was best, while opponents claimed that school is not the place to teach young people about contraceptive methods and that an abstinence-only curriculum would be better.

The school board passed the abstinence-only curriculum by a 4–3 vote. It will review the curriculum in three years, but until then, students in Oconto will receive no information on contraception or prevention of STDs.

### **Support for Comprehensive Sexuality Education**

Although the examples described above illustrate a variety of outcomes, communities around the country are beginning to mobilize for comprehensive sexuality education.

- Polls conducted in 1993 in North Carolina and New Jersey found overwhelming support for comprehensive sexuality education, including for teaching contraception and safer sex measures to young people. In North Carolina, 90 percent of adults agreed that sexuality education should be taught in the public schools; 87 percent favored offering education about birth control. In New Jersey, 94 percent of adults approved of teaching about HIV/AIDS, and 86 percent approved of teaching about contraception and safer sex.
- In Newton, Framingham, and Concord, Massachusetts, school committee elections turned on whether or not candidates supported a comprehensive approach to sexuality education. In each community, voters turned out to elect school committee members who favored a comprehensive approach.

- In New Jersey, then-governor James Florio vetoed a bill to require that family life education courses "stress abstinence," on the grounds that the bill would undermine local control over curriculum decisions. Although a similar bill was reintroduced in 1994, legislators are now aware of the tremendous support that exists in New Jersey for a comprehensive approach to sexuality education.
- In Oregon, two community programs are being challenged for not being comprehensive enough. Under state law, programs in human sexuality must be "comprehensive" and "promote abstinence for school age youth and mutually monogamous relationships with an uninfected partner for adults as the safest and most responsible sexual behavior. However, abstinence shall not be taught to the exclusion of other material and instruction on contraceptive and disease reduction measures."
- Numerous communities have rejected fear-based curricula and opted to strengthen the existing courses or adopt prepackaged programs that have been effective in delaying the onset of intercourse and helping sexually active teenagers to use contraception and protect themselves from STDs, including HIV.

### **Conclusion**

The mobilization of opponents of comprehensive sexuality education in local communities remains the largest barrier to such education. If enough parents and other community members organize to promote effective, accurate sexuality education at the local level, fear-based programs will be defeated. While polls show that most people favor a comprehensive approach, opposition to comprehensive programs often appears at local school board meetings, leaving the perception that most people want fear-based curricula taught. Many people are unaware that controversy exists within their community. Others fail to see the connection between conflict over sexuality education and the larger radical right agenda. Some feel uncertain about effective actions to ensure a comprehensive approach. But the bottom line is that the health of children and youth depends on broader community involvement—from parents, teachers, administrators, religious leaders, community-based organizations, and business leaders.

### **References**

1. The Alan Guttmacher Institute, *Sex and America's Teenagers* (New York, 1994).
2. A. E. Gambrell and D. W. Haffner, *Unfinished Business: A SIECUS Assessment of State Sexuality Education Programs* (New York: Sex Information and Education Council of the U.S., 1993).
3. The information in this section has been documented by local newspapers and obtained through a clipping services. Additional information has been provided by community members.

# **THE GOOD NEWS ABOUT SEXUALITY EDUCATION, 1994**

**Debra W. Haffner, M.P.H.**

**I**t is easy for a sexuality educator to feel discouraged and overwhelmed these days. Attacks on comprehensive sexuality education are increasing; sexuality educators are concerned about their ability to continue to teach in their communities; fear-based, abstinence-only programs are being proposed in state legislatures and the Congress. At times, I feel that we are struggling just to stay in place.

However, I am struck by how far we have come in the battle for sexuality education and sexual rights. As readers of the *SIECUS Report* know, SIECUS is celebrating its thirtieth anniversary this year. Over the last several months, I have reread many documents from the SIECUS archives, and it is clear that changes have occurred that would have been unimaginable at our founding.

Thirty years ago, no state mandated sexuality education, conservative organizations opposed all teaching about sexuality in schools, and professional organizations ignored the topic completely.

Today, federal and state governments are calling for sexuality education. Surgeon General Joycelyn Elders has been eloquent in describing the need for sexuality education and comprehensive health education. (See article on page 1.) Almost every state mandates or recommends that schools provide sexuality education. All states recommend or require teaching about HIV/AIDS.

There is vast public and professional support for sexuality education. National, state, and local polls all demonstrate similar results. More than eight in ten parents support the provision of sexuality education in the public schools, and more than nine in ten support HIV/AIDS education. Significant majorities favor teaching about such issues as safer sex, contraception, and sexual identity and orientation.

Dozens of national organizations support comprehensive sexuality education. Eighty-four such organizations have joined the SIECUS-led National Coalition to Support Sexuality Education, and each is committed to working to assure that comprehensive sexuality education is available to all children and youth by the year 2000.

Even organizations that traditionally have opposed

sexuality education now favor it. Many conservative groups support teaching young people about growth and development, puberty, marriage and family life, dating, and communication. The focus of the vast number of community struggles we witnessed in the last school year focused not on whether sexuality education should be taught, but on what subjects it should include. (See article on page 11.)

I am especially encouraged by recent published evaluations on sexuality education. In one study, Douglas Kirby, director of research at ETR Associates, reviewed twenty-three U.S. sexuality education programs and concluded the following:

- Sexuality and HIV education programs do not hasten the onset of intercourse, nor do they increase the frequency of intercourse or the number of sexual partners.
- Skill-based programs can significantly delay the onset of sexual intercourse and increase contraceptive and condom use among sexually experienced youth.<sup>1</sup>

A review of nineteen studies on sexuality education programs, commissioned by the World Health Organization, produced similar conclusions:

- No study revealed evidence that sexuality education leads to earlier or increased sexual experience, and several indicated that it is associated with delays.
- Ten studies showed that sexuality education increases the adoption of safer practices by sexually experienced youth.
- School programs that promote both the postponement of sexual intercourse and the use of condoms when intercourse occurs are more effective than those that promote abstinence alone.<sup>2</sup>

Further, we now have clear indications about what makes programs effective. The challenge, then, is to integrate this information into school-based programs.

Sexuality education programs must do the following:

- Address young people before they become sexually involved.
- Emphasize peer norms and skill building, as well as provide information.
- Focus specifically on reducing risk-taking behaviors, such as by teaching negotiation and resistance skills.
- Include information about abstinence and contraception *and* safer sex practices.
- Use a wide range of teaching methods, including experiential activities.
- Reinforce individual values and group norms.
- Be age-appropriate.
- Be taught by specially trained teachers.

We also know that sexuality education programs must articulate the values that underlie them in order to gain acceptance. We must clearly present the message that sexuality education programs reflect the beliefs of most communities in a pluralistic society. Unlike those who oppose us, sexuality education stands for tolerance, pluralism, and diversity. We need to continue to emphasize that in a pluralistic society, people should respect and accept a range of values and beliefs about sexuality. We perhaps need to remind ourselves that it is this point of view that most Americans want to teach their children. On the days that we feel most beleaguered, we need to remember that our work is critical to assuring that today's young people can become the sexually healthy adults of the twenty-first century.

#### References

1. D. Kirby et al., "School-based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*, 109 (1994): 339-60.
2. "Sex Education Leads to Safer Behavior," *Global AIDS News*, no. 4 (1993).

## ORGANIZATIONS ENDORSE GUIDELINES

The following members of the National Coalition to Support Sexuality Education have officially endorsed the *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade*:

Advocates for Youth  
American Association of Sex Educators,  
Counselors and Therapists  
Association of Reproductive Health Professionals  
Coalition on Sexuality and Disability  
Commission on Family Ministries and  
Human Sexuality, National Council  
of Churches  
Girls Incorporated

Midwest School Social Work Council  
National Coalition of Advocates for Students  
National Education Association  
National Gay and Lesbian Health Foundation  
National Network of Runaway and Youth Services  
Planned Parenthood Federation of America  
Sexuality Information and Education Council  
of the United States  
Society for Behavioral Pediatrics

To order a copy of the *Guidelines*, send \$5.75 to SIECUS Publications, 130 West 42nd Street, Suite 2500, New York, NY 10036.

# DEFINING—AND RECLAIMING— THE MORAL HIGH GROUND

**Deborah M. Roffman, M.S.**

Sexuality Educator and Consultant  
The Park School, Brooklandville, Maryland

Early last school year, I was asked to mentor an intern newly hired to teach middle school health and human sexuality education. A recent bachelor-level health sciences graduate, she won me over instantly with her exuberance, her knowledge, her creativity, and her love for and appreciation of young people. Only when the conversation turned to the topic of "values" did a familiar and worrisome chill begin to work its way up my spine.

"When it comes to value-laden issues," she spouted, as if quoting the official health educator's handbook, "I never take a stand. I tell my students there are no right or wrong answers about morals. We are all free to decide for ourselves."

There it is, fellow sexuality educators. The major Achilles' heel of the field. The baby that sexual health professionals keep throwing out with the bathwater. And the reason why—in the continuing controversy over sexuality education—they may win a few rounds against the "organized opposition," but never, ever the real debate.

In truth, the young woman did not mean what she said, any more than prominent health officials—sexuality education's supreme advocate, Surgeon General Joycelyn Elders, among them—mean it when they say things like, "Our business isn't public morality, it's public health." What the intern could have said (I know this because of how she had earlier described her work in the classroom) was: "In all that I do, I try to highlight and reinforce a core set of universal human values—concepts such as honesty, mutuality, trust, responsibility, respect for self and others. When it comes to values issues that are controversial—such as homosexuality and abortion—I encourage students to think critically about the entire range of disparate viewpoints to which they are exposed, using core human values as a guide."

Until sexuality educators—all of them—understand that their work in sexuality education and health has *everything* to do with "values" and "morality," they will remain open to denigration and attack. In fact, they will invite it, even deserve it. What is morality, I wonder, if it is not the act of supporting young people in making

caring, ethical choices about potentially life-altering issues? What is morality, please tell me, if it is not about providing education and services that aim to sustain, prolong, and protect human life and health? Sexuality educators "know" these things in their hearts, yet fail so often to explain them clearly and emphatically to themselves, let alone to others. And each time they fail, they inadvertently—and inappropriately—cede yet another parcel of "moral high ground" to others.

The successes of the "abstinence-only" movement are due in part to the moral vacuum that this inarticulateness has helped create. The chastity message not only is clear and emphatic, but is always delivered with moral confidence; by comparison, sexuality educators too often appear wishy-washy, relativistic, and even deliberately amoral. In a society that harbors endemic anxiety about the bugaboo of "permissiveness," how easy it becomes to depict them and what they do as a big part of the problem, not the solution.

***What is morality... if it is not about providing education and services that aim to sustain, prolong, and protect human life and health?***

The next movement on the educational horizon for sexuality educators to watch closely is "character education," highlighted in the November 1993 issue of the Association for Supervision and Curriculum's journal *Educational Leadership*. This edition of that widely read journal should be required reading for all sexuality educators. Reflecting broad-based national concern that our society has lost sight of its moral compass, character educators place blame in part on the reluctance of public and private schools to explicitly teach about traditional values. Offering a multitude of excellent suggestions in more than a dozen articles, experts in

the field explore theories of moral development and a variety of issues concerning the moral climate of schools. They describe strategies for encouraging students to engage in personal reflection, moral discipline, cooperative learning, and conflict resolution, and they highlight a variety of ethics courses, parent involvement initiatives, and community service and mentoring programs.

While education for character is certainly a concept that many, if not most, parents and educators will embrace both morally and philosophically, they will need to be aware that as a practical matter, the movement is also a natural bedfellow for the lobby against sexuality education. For the organized opposition, and for some of the central figures in the character education movement, "character" and "chastity," and "premature" and "premarital," are morally one and the same. Unless they do their homework beforehand, some parents and educators who encourage the adoption of character education in their schools—and who also support comprehensive sexuality education—may be unhappy to discover that they have unwittingly bought into an abstinence-only approach.

Of even greater concern are the alarms being sounded by some character educators about comprehensive sexuality education and, by implication, about those who teach it. The argument, strenuously advanced, is that anything other than abstinence-only sexuality education *directly* undermines the development of charac-

ter in young people. At the risk of oversimplifying, the logic appears to be that sexuality educators' willingness to provide information about prevention destroys young people's willingness to exercise self-control, a mainstay of character.

The notion that sexuality education may be harmful is certainly not new. (How many times has it been said that "knowing leads to doing," and that by giving young people opportunities to know, sexuality education encourages them to do?) This new accusation, however, cuts much deeper than traditional, misplaced anxieties about sexual knowledge. Here, sexuality educators are being indicted *directly*, as agents in the destruction of children's moral fiber.

As ugly and outrageous as the charge may be, it is one that the profession cannot ignore. It is attached, if at the moment only peripherally, to a movement with phenomenal appeal that will most likely continue to gain in visibility, popularity, and credibility.

If character development is indeed the new wave of affective education's future, the challenges for sexuality educators will be formidable. It will be up to them to help differentiate "character education" from "chastity education," and explain truly comprehensive sexuality education in relation to both. And they will need to begin by defining and establishing—far more lucidly than they have done in the past—the complex, subtle, and critical relationships between values, morality, and exactly what it is that they are attempting to do.

## CALL FOR SUBMISSIONS

Following is a schedule of themes for the coming volume of the *SIECUS Report* (volume 23). If you are interested in submitting an article, a related book or video review, or a critical analysis of the issues, send a draft manuscript, double-spaced, to Dore Hollander, Editor, *SIECUS Report*, 130 West 42nd Street, Suite 2500, New York, NY 10036. (Detailed instructions for authors appear on page 28.)

### Media and Censorship Issues

October/November 1994

*Deadline:* September 6, 1994

### AIDS: Next Steps in Prevention Education

December 1994/January 1995

*Deadline:* October 1, 1994

### Race, Class, and Sexuality

February/March 1995

*Deadline:* December 1, 1994

### Meeting the Needs of People with Developmental Disabilities

April/May 1995

*Deadline:* February 1, 1995

### Medical and Health Care Issues

June/July 1995

*Deadline:* April 1, 1995

### Adolescent Sexuality and Sexual Health

August/September 1995

*Deadline:* June 1, 1995

# **SIECUS Fact Sheet**

## **Comprehensive Sexuality Education**

### **ADOLESCENTS AND ABSTINENCE**

*The media have declared a new "chastity," or "virginity," trend among today's adolescents. The data about teenage sexual activity, however, tell another story.*

#### **DATA ON TEENAGE SEXUAL BEHAVIOR<sup>1</sup>**

- Rates of sexual activity among teenagers have risen throughout the last thirty years.
- In the mid-1950s, just over a quarter of women under age eighteen were sexually experienced. Between 1962 and 1970, rates of sexual activity for women this age were fairly constant at 30–35 percent. During the 1970s, the proportion of young women having sexual intercourse prior to age eighteen rose from 35 percent to 47 percent. During the 1980s, rates of sexual activity began to level off. Today, the proportion of eighteen-year-old women who have had intercourse at least once is 56 percent.
- In 1970, 55 percent of men had had intercourse by age eighteen. During the 1970s, this proportion rose to 64 percent; today, it is 73 percent.
- A significant proportion of adolescents remain abstinent: nearly 20 percent of young people do not have intercourse during their teenage years.
- Almost all adolescents participate in sexual activity of some kind. Overall, 90 percent have kissed, 79 percent have participated in deep kissing, 72 percent have participated in touching "above the waist," and 54 percent have participated in touching "below the waist."<sup>2</sup>
- Sexual activity is fairly rare among the youngest teenagers, but becomes increasingly common with age. The proportion who are sexually active is 9 percent among twelve-year-olds, but rises to 23 per-

cent among fourteen-year-olds, 42 percent among sixteen-year-olds, and 71 percent among eighteen-year-olds.

- For women, the interval between puberty and first marriage has lengthened significantly since the turn of the century—from roughly seven to about twelve years. On average, women reach puberty (begin menstruating) at age twelve and one-half, and first marry at age twenty-four. For men, puberty (marked by sperm production) begins at age fourteen, and first marriage occurs at age twenty-six, on average.

#### **COMPREHENSIVE SEXUALITY EDUCATION CAN HELP TEENAGERS TO POSTPONE INTERCOURSE**

- Helping adolescents to postpone sexual intercourse until they are ready for mature relationships is a key goal of comprehensive sexuality education.<sup>3</sup> Sexuality educators have always included information about abstinence in sexuality education courses.
- Interventions that are effective in encouraging teenagers to postpone sexual intercourse help young people to develop the interpersonal skills they need to resist premature sexual involvement. Effective programs include a strong abstinence message, as well as information about contraception and safer sex. For interventions to be most effective, teenagers need to be exposed to these programs before initiating intercourse.<sup>4</sup>
- In a 1993 study, SIECUS found that state curricula emphasize abstinence. Abstinence is among the

topics most often covered in state curricula and guidelines, along with families, decision making, and sexually transmitted diseases and HIV. The topics least likely to be covered include sexual identity and orientation, shared sexual behavior, sexual response, masturbation, and abortion.<sup>5</sup>

### **ABSTINENCE-ONLY PROGRAMS NOT PROVEN EFFECTIVE**

- Only three studies of school-based abstinence-only programs have been published in the professional literature. These studies did not find any impact of such programs on adolescents' initiation of intercourse.<sup>6</sup>
- Sexuality education programs that teach only abstinence have not proven effective. The research that exists on these programs tends to have serious methodological flaws, such as not asking students about their sexual behavior before and after their participation in the program.
- No available evidence supports the effectiveness of having young people sign pledges that they will not engage in intercourse until marriage.
- Nearly two-thirds of teenagers think teaching "Just Say No" is an ineffective deterrent to teenage sexual activity.<sup>7</sup>

### **References**

1. Data on teenage sexual behavior have been adapted from The Alan Guttmacher Institute, *Sex and America's Teenagers* (New York, 1994).
2. Roper Starch Worldwide, *Teens Talk about Sex: Adolescent Sexuality in the 90's* (New York, 1994).
3. National Guidelines Task Force, *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade* (New York: Sex Information and Education Council of the U.S., 1991).
4. D. Kirby, "School-based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness," *Public Health Reports*, 109 (1994): 339-60.
5. A. E. Gambrell and D. W. Haffner, *Unfinished Business: A SIECUS Assessment of State Sexuality Education Programs* (New York: Sex Information and Education Council of the U.S., 1993), 18.
6. S. Christopher and M. Roosa, "An Evaluation of an Adolescent Pregnancy Prevention Program: Is 'Just Say No' Enough?" *Family Relations*, 39 (1990): 68-72; M. Roosa and S. Christopher, "Evaluation of an Abstinence-only Adolescent Pregnancy Prevention Program: A Replication," *Family Relations*, 39 (1990): 363-67; and S. R. Jorgensen, V. Potts, and B. Camp, "Project Taking Charge: Six-month Follow-up of a Pregnancy Prevention Program for Early Adolescents," *Family Relations*, 42 (1993): 401-06.
7. Roper Starch Worldwide, *Teens Talk about Sex*.

*This fact sheet was developed by Leslie M. Kantor, M.P.H., director of the SIECUS Community Advocacy Project, and Debra W. Haffner, M.P.H., executive director of SIECUS.*

### **Get the Facts with SIECUS Fact Sheets**

SIECUS fact sheets offer quick access to important information concerning comprehensive sexuality education. The following fact sheets are available:

- National Coalition to Support Sexuality Education
- Sexuality Education and the Schools
- The Far Right and Fear-based Abstinence-only Programs
- Sexual Orientation and Identity
- The Truth about Latex Condoms

Single copies can be obtained free on request. Please send a stamped, self-addressed business-size envelope to Publications Department, Sexuality Information and Education Council of the United States, 130 West 42nd Street, Suite 2500, New York, NY 10036. All fact sheets may be reproduced without permission, as long as credit is given to SIECUS.

# AMERICAN PUBLIC HEALTH ASSOCIATION ADOPTS RESOLUTION ON SEXUALITY EDUCATION

*At its 1994 annual meeting, the American Public Health Association (APHA), which is a member of the SIECUS-led National Coalition to Support Sexuality Education, passed resolution 9309, calling for comprehensive sexuality education for children and youth. The resolution reads as follows:*

The American Public Health Association,

Noting that APHA Resolution 6917: Sex Education in School Systems, adopted in 1969, urged parents, churches, school personnel, and community groups to work toward strengthening their school systems in their efforts to develop informed, well-adjusted, and productive citizens by placing sex education and family life as an integral part of total education, and further that schools of higher education be charged with sound preparation of teachers of family life and sex education,<sup>1</sup>

Acknowledging that while more than one-half of American high school students have had sexual intercourse, and face significant health risks which include: fewer than half of those students use condoms regularly,<sup>2</sup> each year approximately one million adolescent girls become pregnant,<sup>3</sup> 86 percent of all sexually transmissible diseases (STD's) occur among persons aged 15-29 years,<sup>4</sup> and the number of adolescents diagnosed with HIV infection has increased dramatically for several years,<sup>5</sup>

Recognizing that sexuality is a normal, healthy aspect of human development, that sexuality education is a lifelong process,<sup>6</sup> and that individuals of all ages require complete and accurate information about all aspects of sexuality.

Noting that leading sexuality organizations define comprehensive sexuality education as the provision of honest, realistic, accurate and positive information about human sexuality, including information about prevention of unintended or too early pregnancy, sexually transmissible diseases, reproductive and sexual health care, and sexual behavior including the skills necessary for refusing unwanted sexual contact, negotiating sexual relationships, and making responsible, healthy decisions;<sup>6</sup> therefore, APHA

1. Endorses the right of children and youth to receive comprehensive sexuality education including facts, information and data and demonstrating an appreciation of racial, ethnic, and cultural diversity. Such education should foster skills to communicate effectively and to make responsible decisions, and should be delivered by qualified educators who have received specialized training in health, health education and human sexuality; and
2. Urges local and/or state Boards of Education to include comprehensive sexuality education as an integral part of K-12 comprehensive school health education program by guidelines or mandates with a curriculum that is carefully developed, developmentally- and age-appropriate, and respectful of the diversity of values and beliefs represented in the community and taught by qualified educators who have received specialized training in health, health education, and human sexuality; and
3. Urges that sexuality education programs be implemented in such a manner that is non-judgemental and does not impose religious, ethical, or moral values on students.

## References

1. American Public Health Association, Resolution No. 6917: Sex Education in School Systems, in *APHA Public Policy Statements, 1948-Present*, cumulative (Washington, DC, current volume).
2. Centers for Disease Control (CDC), "Sexual Behavior among High School Students—United States, 1990," *Morbidity and Mortality Weekly Report*, 40 (1992): 885-88.
3. C. D. Hayes, ed., *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, vol. I (Washington, DC: National Academy Press, 1987).
4. CDC, Division of STD/HIV Prevention, *Annual Report*, 1990 (Atlanta, 1991).
5. J. Brooks-Gunn, C. B. Boyer, and K. Hein, "Preventing HIV Infection and AIDS in Children and Adolescents: Behavioral Research and Intervention Strategies," *American Psychologist*, 43 (1988): 958-64.
6. National Guidelines Task Force, *Guidelines for Comprehensive Sexuality Education: Kindergarten-12th Grade* (New York: Sex Information and Education Council of the United States, 1991).

# NATIONAL COMMISSION ON ADOLESCENT SEXUAL HEALTH

During the past two decades, prevention programs have focused on reducing the morbidity related to adolescent sexual behaviors. A clear consensus has emerged about what is sexually unhealthy for teenagers. Too many young people are faced with unplanned pregnancies; sexually transmitted diseases, including HIV infection; sexual abuse; and parenting responsibilities.

In this same period, sexual intercourse has become normative behavior for the nation's adolescents. Despite the concerns about unhealthy sexual behaviors, little dialogue or consensus has emerged about what is sexually *healthy* for adolescents. To address the pressing need for leadership on adolescent sexual health, and to develop a national professional consensus on this issue, SIECUS has convened the National Commission on Adolescent Sexual Health, whose members are leading adolescent sexuality professionals from universities, national organizations, the media, and public office. Commission members have expertise in medicine, religion, psychology, child

development, education, policy, and ethics.

At their first meeting, on May 16, 1994, the commissioners began developing a consensus statement on adolescent sexual health. They will conduct a series of meetings and hearings throughout the next year, and will issue a report in June 1995. The Commission's report will address such issues as the emotional and psychological implications of sexual behavior in early, middle, and late adolescence; long-term implications of adolescent sexual behavior; and program models that have been effective in changing adolescent sexual behavior. It will include recommendations for policy makers, the media, and national organizations. The report will be widely distributed to the media; key federal, state, and local policy makers; national youth-serving organizations; professionals; and the general public.

Initial funding for the National Commission on Adolescent Sexual Health has been provided by the Ford Foundation and the Office of Population Affairs, U.S. Department of Health and Human Services.

## MEMBERS OF THE NATIONAL COMMISSION ON ADOLESCENT SEXUAL HEALTH

### **Robert L. Johnson, M.D.**

(Commission Chair)

New Jersey Medical School

### **Eugene Beresin, M.D.**

Harvard Medical School

### **Robert Blum, M.D.**

University of Minnesota

### **Michael Carrera, Ed.D.**

Children's Aid Society

### **Arthur B. Elster, M.D.**

American Medical Association

### **Jacqueline Darroch Forrest, Ph.D.**

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### **Donald E. Greydanus, M.D.**

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### **Douglas Kirby, Ph.D.**

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### **Ruby Takanishi, Ph.D.**

Carnegie Council for  
Adolescent Development

### **Betsy Wacker**

SIECUS

### **Beth Winship**

"Dear Beth"

## • BOOKS & VIDEOS • BOOKS & VIDEOS •

### LOSING IT: THE VIRGINITY MYTH

Louis M. Crosier, Editor  
Washington, D.C.: Avocus Publishing,  
1993, 195 pp., \$19.95 hardcover,  
\$12.95 paperback

*Losing It* is a compilation of first-person stories about how twenty-two young people—male and female, heterosexual, lesbian, and gay—lost their virginity. These young people recount the fears, pressures, and misconceptions that preceded their loss of virginity and explain their experiences and their feelings afterward. Interspersed throughout the book are comments by health professionals, teachers, and social workers on relevant issues.

*Losing It* takes the mystery out of virginity loss and reveals it to be but one experience along the road to sexual maturity—not the definitive sexual experience of a lifetime. The book exposes the conflicting pressures young people face both to keep and to lose their virginity. One young woman, for example, describes the shame and guilt she felt after losing her virginity because she was raised to believe that only "sluts" had intercourse before marriage. A young man, on the other hand, recounts his desire to impress his best friend with his sexual exploits. Although the pressures men and women face are often very different, *Losing It* also reveals the similarities that exist in their feelings about their experiences.

One man says, "The day after I 'lost it,' I felt totally agitated, cheated, confused, alone." A young woman remarks, "The most special night of my life turned into a nightmare." Although positive experiences are recounted, many authors speak of the dissatisfaction, disappointment, and regret they experienced after "losing it," and of their complete unpreparedness for these feelings. These stories offer the reader a realistic notion of what losing one's virginity is all about and the emotional consequences of this event.

Although there is no lack in representation of the negative issues related to sexual intercourse—contraction of a sexually transmitted disease, unintended pregnancy, date rape—these stories do not provoke fear so much as contemplation. Readers will find themselves

reflecting upon their own expectations and experiences. *Losing It* thus plays a vital role as an instigator of insight into and discussion of virginity, as well as other aspects of sexuality.

*Reviewed by Robin Finn, the recipient of the first Bobbie Whitney Memorial Internship at SIECUS.*

### SEX, LIES, AND THE TRUTH

Focus on the Family, 30 min., 1993.  
Distributed by Focus on the Family,  
Educational Resources, PO Box 15379,  
Colorado Springs, CO 80935-9951.  
\$85.00.

Focus on the Family has produced a slick video, intended for use in public junior high schools, on what it considers the dangers of premarital sexual activity. Through medical inaccuracies, scare tactics, and sexist and racist stereotypes, the video sends the message that adolescents should abstain from sexual behavior until marriage.

Despite this message, the video uses sexual imagery to make its case. The narrators are Kirk Cameron and Chelsea Noble, two teenage heartthrobs, who discuss abstinence while making it clear that they are married and sexually active. A discussion about sexual images in the media is accompanied by a montage of advertisements featuring sexy women.

While the video includes young people of diverse backgrounds, it plays into racial stereotypes. For example, it features an African American young woman, whose boyfriend is in jail, discussing being a single mother.

The video is riddled with medical misinformation. In classroom settings, Miles McPherson, a former professional football player, tells the students that a few years ago, there were only five sexually transmitted diseases (STDs), and that there are now over twenty. He attributes this change to people's "becoming more perverted, having dirtier sex." These assertions are patently false.

McPherson also tries to link the rise in pregnancy, abortion, and teenage sexual activity rates to the safe sex campaign, which he says started twenty years ago. Actually, the concept of safe sex was developed in the early 1980s,

as a response to AIDS. Furthermore, both pregnancy and abortion rates among sexually experienced teenagers are declining.<sup>1</sup>

Elsewhere in the video, spokespersons of various far right organizations provide misinformation about the effectiveness of condoms in preventing pregnancies and STDs, the likely time during any month that a woman may conceive, and the relationship between STDs and future infertility. Meanwhile, they offer no information about ways to protect one's sexual health.

Examples of sexism in the video include a segment in which a young man fails to win a carnival game, but his girlfriend immediately succeeds. The young man looks dejected, and the voiceover suggests that the game requires no skill and is fun only when won. The message: women's achievements in activities at which men traditionally excel make men unhappy.

Fear and shame will not motivate students to postpone sexual involvement. The video provides no incentives for remaining sexually abstinent other than the use of role models who state that they waited until marriage to have intercourse. It omits any helpful information about sexual health, such as how to avoid pregnancy and STDs other than through abstinence.

In the video, baseball player Orel Hershiser proclaims: "Nothing good is easy." This statement can certainly be applied to the task of providing sexuality education for young people. Although mandating abstinence and telling horror stories about the dangers of sexual activity seems an easy answer, the better approach is to give teenagers accurate, up-to-date information about reducing their risks, as well as opportunities to develop the interpersonal skills critical to making healthy decisions about sexuality. *Sex, Lies and the Truth* neither increases students' knowledge nor illustrates helpful strategies for remaining sexually healthy.

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*Reviewed by Leslie M. Kantor, M.P.H., director of the SIECUS Community Advocacy Project.*

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