

GENDER EQUITY IN FORMAL SEXUALITY EDUCATION

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[AQ1]

INTRODUCTION

This chapter examines gender and gender equity issues in formal sexuality education and considers the adequacy of formal programs from several vantage points. I begin with definitions of terms that are central to the analysis. Next, attention turns to the current state of sexuality education. I will, in turn, consider formal education in K–12 schools, colleges and universities, and medical schools; the reader will note that there is more material available regarding the first than about the second or third. With this survey as background, I will discuss several gender equity issues; this section will include discussion of programs designed to address these issues. The chapter ends with conclusions and recommendations.

DEFINITIONS

To discuss formal sexuality education programs, we need a way of classifying or defining extant programs. To be sure, there are no universally accepted definitions. The following terms are widely used:

- *Sexuality education.* The lifelong process of acquiring information about sexual behavior, and of forming attitudes, beliefs, and values about identity, relationships, and intimacy (SIECUS, 1999). Notice that this broad definition includes considerations of sexual health and quality of interpersonal relationships. A program of this type for girls ages 9–17, *Preventing Adolescent Pregnancy* by Girls Incorporated (1991), consists of four age-appropriate components. Most of the available curricula are much more narrowly focused.
- *Theoretically based (comprehensive) sexuality education.* Programs that include information about sexual behavior, sexual relationships, and sexual health; they are based on em-

pirically tested theories of health promotion. These programs often teach abstinence as the best method for preventing unwanted pregnancy and sexually transmitted infections (STIs) but also provide information about condoms and contraception (Advocates for Youth, 2006). Two of the major curricula of this type are Postponing Sexual Involvement (middle school–age youth), and Reducing the Risk (high school–age youth). Such programs typically include discussion of social pressures to engage in sexual intimacy and resistance techniques. Implementation of these programs varies greatly, ranging from 10 sessions presented in a single year or grade to a more extensive program presented in multiple years or grades.

- *Abstinence plus programs.* Promote abstinence as the preferred option for adolescents but permit discussion of contraception as an effective means of reducing the risk of unwanted pregnancy and disease. These curricula may include discussion of sexual behavior, sexual relationships, and sexual health; they may be based on empirically tested theories of health promotion. Implementation of these programs also varies greatly, as indicated above.
- *Abstinence only programs.* Promote abstinence from sexual intimacy as the sole morally correct means of preventing pregnancy and STIs for persons who are not heterosexually married (includes *abstinence-only-until-marriage*). Such programs do not present positive information about condoms and contraceptives but may highlight their failure. One of the major curricula of this type is Sex Respect, which is known for the slogans that are taught as part of the program, such as “Pet your dog, not your date.” These curricula often focus on negative or problematic aspects of sexual intimacy. According to the literature evaluating these programs (e.g., Minnesota Department of Health, nd), some involve 5 sessions, others 12, and others meet weekly for an academic year. Lessons may be classroom-based during the school day or after school, presented in a community services setting, or presented in a faith-based community.

- *HIV/AIDS risk education.* Refers to educational programs sharply focused on disease prevention. These curricula challenge myths about transmission and curability; they encourage delay of intercourse and condom use if sexually active. Such programs are presented in six to eight sessions. Examples include Act Smart and Choosing Health.

These programs are implemented in a variety of settings including: schools as part of a general education curriculum; after-school programs that meet in schools, churches, community centers; and other similar settings. Both state and federal evaluations point out that the students who typically enroll in the nonclassroom programs are volunteers and therefore may be predisposed to be positively influenced by the program in which they enroll. Many nonclassroom programs are presented by volunteer teachers from the community or employees of the contractor who provides the programming. Wherever they are presented, the effectiveness of these programs depends on the training and attitudes of the instructors (de Gaston, Jensen, Weed, & Tanas, 1994).

THE CURRENT STATE OF SEXUALITY EDUCATION: K–12

How widely are these programs used in the United States? Landry, Kaeser, and Richards (1999) mailed a questionnaire to a representative sample of 1,224 U.S. school districts in 1998; 825 completed surveys were returned. Sixty-nine percent of the districts reported having a district-wide policy. Of those, 14% had a policy requiring comprehensive education. An additional 51% required an abstinence-plus program; 35% (or 23% of all districts responding) required an abstinence-only curriculum. Based on the size of the reporting districts, Landry and colleagues estimated that, of all children in grades six and higher, only 9% were in a district requiring comprehensive sex education; 45% were in districts with an abstinence-plus policy, 32% in districts requiring abstinence-only, and 14% in districts with no policy.

According to the Alan Guttmacher Institute (2006), 21 states and the District of Columbia require public schools to teach sex education. Twenty-one states, including some that do not require sex education, require that abstinence be stressed; 14 states and the District of Columbia require that programs include contraception education. Thirty-seven states and the District of Columbia require that STI/HIV education be provided, and 26 of these require that abstinence be stressed.

The data on district policies and state laws suggests that the content of sex education in K–12 schools varies a great deal. It appears that a minority of young women and men get comprehensive sex education in their public schools. Perhaps a third receives abstinence-only instruction. The most common approach, based on the data presented above, seems to be narrowly focused STI/HIV prevention education.

That sex education programs focus on the risks and dangers of sexual activity is not new. This emphasis has been present since sex education programs began in the early 20th century (Rury, 1992). The first programs grew out of fear over the spread

of sexually transmitted diseases, for which there was no cure at the time. In addition, some supporters saw sex education as the way to combat the evils of promiscuity and prostitution. Classes were often taught separately to girls and boys, which allowed educators to discuss sexuality in very different terms for men and women. Thus, sex education did not challenge traditional views of gender and gendered views of sexuality, and probably reified them. These characteristics profoundly influenced the content and process of sex education.

In the past 25 years a political battle has developed over sex education. A group allied with conservative Christian churches, the Republican Party, and conservative think tanks such as the Heritage Foundation have increasingly lobbied against theoretically based (comprehensive) programs. They claim that giving information to young people about sexual intercourse, birth control to prevent unwanted pregnancy, and ways to protect themselves against STIs encourages them to engage in sexual intercourse. They argue that comprehensive programs have not been effective.

EVALUATING EFFECTIVENESS

In the context of this debate, how is effectiveness defined? To evaluate sexuality education programs, we have to establish criteria for evaluation. At the level of social policy, it is fair to say that concern about, and support for, sexuality education in the schools grows out of the recognition of two major public health problems: teen pregnancy and STIs. In 1999, there were 856,300 pregnancies involving women under age 20 in the United States (Henshaw, 2003). A significant number are terminated by abortion; Henshaw estimates that in 1999, 249,660 (29%) were terminated by abortion, accounting for 20% of the abortions in the United States. Obviously, preventing these pregnancies would reduce the number of abortions. If carried to term, many of these babies have low birth weight and suffer from health problems; this may reflect the mothers' health and lack of access to prenatal care. Most of the mothers are single and may lack social and economic resources necessary for optimal child development.

Sexually transmitted infections are epidemic in the United States. It is estimated that there are 3 million new cases of chlamydia, 5.5 million cases of HPV/genital warts, and 650,000 new cases of gonorrhea every year (CDC, 2000). The numbers of reported cases are much smaller; in 2003 there were 877,478 cases of chlamydia, 34,270 cases of syphilis, and 335,104 new cases of gonorrhea (National Center for Health Statistics, 2005). The discrepancy reflects the fact that many cases are not diagnosed or reported. These STIs have economic and emotional costs and are probably the leading cause of infertility among both men and women.

In this context, there is overwhelming public support for sexuality education programs in schools. A 1999 poll by Hickman-Brown based on interviews with a nationally representative sample of 1,050 adults found that 68% supported comprehensive sexuality education in grades 9 and 10, and at least 79% supported it in grades 11 and 12 (SIECUS, 1999). According to a 1999 survey conducted for the Kaiser Family Foundation (2000), 82% of parents of children under 18 supported comprehensive

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programs. Thus, there is no battle in the realm of public opinion over what should be taught in sex education programs. Note also the disconnect between public opinion and the policies of K–12 school districts reviewed earlier.

Considering these problems, it is appropriate to use some or all of five criteria to evaluate the effectiveness of sex education programs:

1. Delayed initiation of sex
2. Decreased frequency of intercourse
3. Decreased number of partners
4. Increased use of condoms if sexually active
5. Increased use of contraception if sexually active

These criteria have been employed in most of the sex-ed evaluation research to date. The second and fifth criteria presume heterosexual vaginal intercourse; to the extent that these criteria are the focus of educational programs, such programs do not speak to the concerns of lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth. The other criteria can, in principle, be applied to all forms of partnered activity.

WHAT WORKS?

There have been numerous studies of the effects of various types of formal sexuality education programs. These studies have been conducted in a variety of ways for the past 25 years. Kirby (2001, 2002) has reviewed this literature several times in

the past 10 years. Many of the studies are methodologically weak. We are most interested in the results of those studies that meet the following rigorous methodological standards:

- Random assignment of youth or groups to condition, to counter “volunteer” effects
- Combined sample of at least 500, to achieve large enough subsamples to provide sufficient power for statistical analyses of the data
- Long-term follow-up, at least 12 to 18 months
- Measurement of pregnancy rates
- Measurement of sexual behavior, instead of attitudes or intention
- Proper statistical analyses
- Publication of results to allow assessment by peer review.

Based on a review of studies that meet these criteria (displayed in Table 19.1, column 1) there is no evidence that comprehensive sexuality education programs hasten the onset of intercourse, increase the frequency of sex or number of partners, or decrease use of condoms or contraceptives (Kirby, 2001). Thus, one of the major criticisms of comprehensive sexuality education programs by its opponents is not supported by empirical data.

Supporters of abstinence-only sexuality education programs argue that youth need to be encouraged to abstain from sex, and that this can be done by withholding information about sexuality, birth control, and STI prevention, as well as by inoculating youth through the use of slogans against pressure to be sexual

TABLE 19.1 The Number of Programs with Effects on Sexual and Contraceptive Behaviors by Type of Program

	Abstinence-Only Programs	Sexuality Education Programs	HIV Education Programs	Sum of Sexuality and HIV Education Programs
Initiation of Sex				
Delayed initiation	0	6	3	9
Had no significant impact	3	12	6	18
Hastened initiation	0	1	0	1
Total Number of Programs	3	19	9	28
Frequency of Sex				
Decreased frequency	0	2	3	5
Had no significant impact	2	8	5	13
Increased frequency	0	1	0	1
Total Number of Programs	2	11	8	19
Number of Sexual Partners				
Decreased number	0	0	3	3
Had no significant impact	1	4	3	7
Increased number	0	0	0	0
Total Number of Programs	1	4	6	10
Use of Condoms				
Increased use	0	2	8	10
Had no significant impact	1	5	3	8
Decreased use	0	0	0	0
Total Number of Programs	1	7	11	18
Use of Contraception				
Increased use	0	4	0	4
Had no significant impact	1	7	0	7
Decreased use	0	0	0	0
Total Number of Programs	1	11	0	11

from peers, mass media, and culture. These people assert that abstinence-only programs will be effective as measured by the criteria discussed above and will lead unmarried persons to delay the onset of intercourse. Obviously, if people don't engage in intercourse, there is no need to decrease the frequency of sex, reduce the number of partners, or increase condom and birth control use.

Again, Kirby reviewed this literature. Looking at the results of those studies that meet rigorous methodological standards displayed in Table 19.1, columns 2, 3, and 4, there is no evidence that abstinence-only educational programs delay the initiation of sexual intercourse and no evidence that they are effective on the other four criteria (Kirby 2002). In short, there is no scientific evidence that abstinence-only sex education programs work.

FEDERAL SUPPORT FOR ABSTINENCE-ONLY PROGRAMS

The debate about what kind of sex education should be taught is complicated by the involvement of the federal government in selectively funding some types of programs and not others. There are two key federal programs.

The national Personal Responsibility and Work Opportunity Act of 1996 (the so-called Welfare Reform bill) provided the states \$250 million over a five-year period to support abstinence-only programs. This provision is set out in Title V of the Social Security Act. States are required to match \$3 for every \$4 in federal funding they receive. Recipients of these funds must agree not to provide any information that is inconsistent with the abstinence-until-marriage message. It is estimated that in 1998–2003, one half billion dollars in state and federal funds were appropriated to support the abstinence-only provision of Title V (Advocates for Youth, 2005).

Federal Definition of "Abstinence-only" Programs (Title V Section 510 (b)(2)(A-H))

- A. Have as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity.
- B. Teach abstinence from sexual activity outside marriage as the expected standard for all school-age children.
- C. Teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems.
- D. Teach that a mutually faithful, monogamous relationship in the context of marriage is the expected standard of sexual activity.
- E. Teach that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects.
- F. Teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society.
- G. Teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances.
- H. Teach the importance of attaining self-sufficiency before engaging in sexual activity.

States receiving federal abstinence education funds must utilize the funds to support programming that meets these criteria. Typically, the federal funds are administered by state departments of health, and often subcontracted to public agencies, faith-based groups, and other contractors who provide the programming. There is wide variation both within and between states in the programming provided. Popular curricula that meet the Title V, Sec. 10 criteria include Education Now Babies Later (ENABL), Why am I tempted? (WAIT), and Family Accountability Communicating Teen Sexuality (FACTS; Advocates for Youth, 2005). Initially, every state received funds except California; California terminated its abstinence-only program in 1996 after an evaluation showed that it was not effective.

In 2001, a separate program, Community-Based Abstinence Education/Special Programs of National and Regional Significance (CBAE/SPRANS), was created to provide funds directly to individual public and private entities that present abstinence-only programming. This program is operated by the Administration for Children and Families. A dramatic increase in funding for abstinence-only programming occurred from 2002 to 2005, with funds allocated by CBAE/SPRANS increasing from \$20 million in 2001 to \$104 million in 2005 (American Foundation for AIDS Research, 2005).

Title V, Section 10 includes a provision requiring an evaluation of the programs funded by it. Initially, this evaluation was carried out by a technical working group, under the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services. The first report (2002) concluded that there is no evidence that abstinence-only education is effective. In 2005, a team from Mathematica Policy Research Inc. released the results of a detailed evaluation of the first-year impact of four programs funded under Title V, Section 10. The report was unable to include behavioral data. The four programs created more positive attitudes toward abstinence and increased perceptions of risks of nonmarital sex; they did not impact self-concept, refusal skills, communication with parents, or perceptions of peer pressure to have sex (Maynard et al., 2005). Given the restricted content of abstinence-only curricula, discussed above, these results are not surprising.

As we entered the seventh year of funding for abstinence-only programs, evaluations undertaken by individual states became available. These include evaluations conducted in Minnesota (Minnesota Department of Health, nd), Pennsylvania (Smith, Dariotis, & Potter, 2003), and Texas (Goodson et al., 2004). Advocates for Youth has obtained evaluation results for Arizona, Florida, Iowa, Maryland, Missouri, Nebraska, Oregon, and Washington. They summarized the results as follows:

Evaluation of these 11 programs showed few short-term benefits and no lasting positive impact. A few programs showed mild success at improving attitudes and intentions to abstain. No program was able to demonstrate a positive impact on sexual behavior over time. (Advocates for Youth, 2005, p. 2)

Abstinence-only education programs funded by state and federal dollars have not been shown to delay onset of intercourse, reduce frequency of intercourse, reduce number of partners, or prevent teen pregnancy through increased use of contraception. These programs do not accomplish the goals their

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supporters claim they accomplish. Based on this evidence and other considerations, Pennsylvania and Maine have joined California in refusing federal abstinence-only funds, and the Rhode Island Department of Education has banned the use of curricula by Heritage of Rhode Island.

Abstinence-only curricula are not effective because they do not provide detailed information about sexual anatomy, sexual physiology, contraception, condoms, and other methods of preventing STIs, nor do they teach teens the skills they need to make healthy decisions and choices with regard to sexuality. Worse, these programs contain misinformation and lies (SIECUS, [AQ4] 2005). For example:

- Condoms provide no proven reduction in protection against chlamydia, the most common bacterial STD (*Choosing the Best PATH*, Leader Guide, p. 18). [AQ5]
- AIDS can be transmitted by skin-to-skin contact (*Reasonable Reasons to Wait*, Teacher's Guide, Unit 5, p. 19). [AQ6]

These programs also promote gender stereotypes as facts. For example:

- "Girls need to be aware they may be able to tell when a kiss is leading to something else. The girl may need to put the brakes on first in order to help the boy." (*Reasonable Reasons to Wait*, Student Workbook, p. 96). [AQ7]
- "A guy who wants to respect girls is distracted by sexy clothes and remembers her for one thing. Is it fair that guys are turned on by their senses and women by their hearts?" (*Sex Respect*, Student Workbook, p. 94). [AQ8]

The first quote reinforces the stereotypic belief that is the girl's responsibility to manage the couple's sexual behavior. The second quote suggests that male and female sexual arousal are governed by different processes.

Congressman Henry Waxman directed the Special Investigations Division of the House to the report more than Committee on Government Reform to assess federally funded abstinence-only programs. According to the report, more than 80% of the abstinence-only curricula, used by over two-thirds of SPRANS grantees in 2003, contain false, misleading, or distorted information about reproductive health. Specifically the report finds:

- Abstinence-only curricula contain false information about the risks of abortion.
- Abstinence-only curricula blur religion and science.
- Abstinence-only curricula treat stereotypes about girls and boys as scientific fact.
- Abstinence-only curricula contain scientific errors. (Committee on Government Reform, 2004).

CHARACTERISTICS OF EFFECTIVE PROGRAMS

As described earlier, five criteria are commonly used to evaluate K–12 sex education programs: delayed initiation of sex, decreased frequency of intercourse, decreased number of part-

ners, increased use of condoms if sexually active, and increased use of contraception and protection if sexually active. Based on careful reviews of 83 evaluation studies that meet most of the methodological criteria reviewed earlier, Kirby, Laris, and Rollieri (2005) identified the characteristics of programs that are successful in achieving one or more of these goals. Successful programs:

- involved a multidisciplinary team in the development of the curriculum
- used a logical approach to specify health goals, and the risk and protective factors related to these goals
- assessed relevant needs and assets of target groups
- designed activities consistent with community values and available resources
- pilot-tested the program
- created a safe social environment for youth
- focused on specific behavioral goals
- focused narrowly on specific behaviors leading to these health goals
- addressed multiple sexual psychosocial risk and protective factors
- included multiple activities to change each of the targeted factors
- employed instructionally sound teaching methods that actively involved participants
- employed activities, methods and messages appropriate to the youths' culture, developmental age, and sexual experience
- covered topics in a logical sequence
- whenever possible, selected educators with desired characteristics and then trained them
- secured at least minimal support from authorities such as school districts and community organizations
- if needed, implemented activities to recruit youth and overcome barriers to their participation
- implemented virtually all activities with reasonable fidelity (Kirby et al., 2005, p. 27).

These authors comment that effective programs were effective among both boys and girls and across the age range from 11 to 23 years of age.

Programs that have been empirically validated and shown to delay onset of intercourse among some groups of teens include Teen Talk (12 to 15 hours), PSI/Human Sexuality and Health Screening (two years), Safer Choices (two years), and Draw the Line/Respect the Line (three years; Manlove, Pappillio, & Ikramullah, 2004). [AQ9] [AQ10]

THE CURRENT STATE OF SEXUALITY EDUCATION: COLLEGE AND UNIVERSITY

There is limited published work on human sexuality courses offered at colleges and universities. Judging from the results of a Google search on "human sexuality courses," such courses are

offered at many colleges and universities. The departments in which the courses are located include Anthropology, Biology, Gender Studies, Health, Human Sexuality Studies, LGBT Programs, Psychology, Sociology, and Schools of Nursing. This list suggests that such courses are probably diverse in content and emphasis. Many are offered for three academic credits, suggesting about 40 class sessions, substantially more than almost any classes at the K–12 level. Therefore, college and university courses are more comprehensive.

A recent qualitative study of one such course obtained questionnaire data from 148 students at the end of the semester (Goldfarb, 2005). Asked whether the course had had an impact on their lives, students' responses fell into five categories:

- Made them better decision-makers and in some cases may affect their behaviors.
- Made them more open-minded and less judgmental, less homophobic.
- Made them more knowledgeable about themselves and their relationships, and in some cases, improved their sex lives.
- Made them into "sexuality educators" in the broadest sense, to people in their lives.
- Made them more comfortable talking about sex and sexuality in their everyday lives.

Modern college textbooks for human sexuality courses tend to be interdisciplinary, covering biological, psychological, and sociological levels of analysis. Most give balanced coverage to female and male sexuality and contain strong coverage of sexual orientation. These textbooks have been able to capitalize on the academic freedom offered by the university setting to offer accurate information about human sexuality. There are, of course, some exceptions, such as books with a heavy biological or evolutionary emphasis, and books that are heterosexist in emphasis.

This admittedly brief discussion suggests that college courses are more comprehensive and have positive impacts on the lives of students who take them. Some of the major textbooks present a more interdisciplinary and gender-equitable perspective, whereas others are characterized by a traditional view of female–male relationships and (hetero)sexual expression. There are no federal restrictions on content of college courses, but there may be state or district restrictions on courses taught in two-year college systems.

There are numerous less formal educational activities on college campuses that are relevant to sexuality education but hard to document. Some are ongoing programs such as sexual wellness peer education internship programs working out of women's centers and student centers. These programs usually focus on healthy sexual communication, and consent issues. A frequently cited campus activity is production of *Vagina Monologues* by Eve Ensler. According to Wikipedia, there are at least 23 colleges and universities that perform *Monologues* annually. Interestingly, while some feminists applaud the play, other feminists join social conservatives in criticizing it, for example, for its anti-male, pro-lesbian elements.

THE CURRENT STATE OF SEXUALITY EDUCATION: MEDICAL SCHOOLS

A recent survey of medical schools reports data on training in human sexuality (Solorsh et al., 2003). Surveys were mailed to 125 medical schools in the United States and 16 schools in Canada; 101 schools responded (74% of the U.S. schools and 50% of the Canadian schools). The majority of schools reported 3 to 10 hours of instruction; most schools (83%) used a lecture format. A multidisciplinary team provided the instruction in 63% of the schools. Topics covered (in descending order by frequency) included causes of sexual dysfunction (94%); treatment of sexual dysfunction (85%); altered sexual identification (79%); and issues of sexuality in illness or disability (69%). Fifty-five percent reported providing supervision during clerkships (clinical work by third- and fourth-year students) that dealt with sexual issues, and 43% offered clinical programs, typically focused on treating patients with sexual problems. The authors concluded that an expansion of medical education may be necessary to provide the community with doctors who are knowledgeable about sexual problems.

There have been studies of the provision of abortion education in medical and allied schools. Espey and colleagues (2005) mailed questionnaires to the OB-GYN clerkship directors of 126 accredited U.S. medical schools; 78 were returned (62%). In the third-year OB-GYN rotation, 32% offered a lecture about abortion; 45% offered a clinical experience, but participation was low. In the fourth year, about half of the schools offered a reproductive health elective, but participation was low. Foster and colleagues (2005) surveyed program directors of the 486 accredited nurse practitioner, physician assistant, and certified nurse midwifery programs in the United States. They also concluded that education is limited, and that this directly affects the quality of women's health care.

In addition to content knowledge, health professionals need the ability to communicate about sexual practices and problems sensitively and without judgment. Published literature suggests that such communication skills are uncommon, indicating the need for more communication skills training in medical schools (Baraitser, Elliott, & Bigrigg, 1998).

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GENDER EQUITY ISSUES IN FORMAL SEXUALITY EDUCATION

The evidence reviewed above suggests that sexuality education in K–12 programs and in medical schools is heavily focused on risk and danger, especially unwanted pregnancy and STIs in K–12 curricula, and sexual dysfunctions and issues of gender identification in medical schools. There is little, if any, discussion of sexual health and its enhancement. There is little attention to whether program outcomes differ for male and female participants. An analysis of the Ontario provincial sex education curriculum concludes that it is focused on risk and danger, that discourses of female victimization and individual morality predominate (Connell, 2005). As noted earlier, this emphasis can

be traced to the roots of the sex education movement. There may be more attention to sexual health and sexual relationships in college courses in human sexuality. Some of the better college courses may provide a model for the necessary expansion of medical education.

Issue 1: Abstinence-Only Sex Education Teaches Gender Stereotypes as Fact

Formal sexuality education often neglects an examination of the ways in which gender role norms and beliefs about masculinity and femininity impact sexual expression and relationships. The critiques of K–12 education (Committee on Government Reform, 2004; SIECUS, 2005) explicitly detail ways in which these materials portray stereotypic male and female traits and behaviors as natural or biological. The result is a view of existing patterns of sexual behavior and sexual interaction as biologically determined. This view is at the root of the double standard that evaluates male nonmarital sexual activity positively, but stigmatizes women for the same behaviors (Whatley, 1992). Thus, sex education often perpetuates the male as active and female as passive view of (hetero)sexual relationships. This view disadvantages both males and females and prevents sexual interactions and relationships from moving toward equal contributions, equal responsibility, and equal pleasure.

Issue 2: Formal Sex Education Focuses on Danger and Ignores Pleasure, Especially Women's Pleasure

A well-documented equity issue in K–12 education is the failure to acknowledge and discuss female sexual desire. Fine (1988) identified the “missing discourse of desire” in sex education programs for adolescents. Based on qualitative research with adolescents, Tolman (2002) wrote about the dilemmas of desire these young women experience. They are immersed in the “sex is risky and dangerous” discourse in sex education and in interactions with parents. They are encouraged to view males as sexual opportunists and to fear sexual victimization. If they experience desire, therefore, it is difficult to acknowledge it. This, in turn, makes it hard for them to express sexual interest and desire, which indeed may lead to engaging in sexual activity because the male wants to and the inability to express agency in heterosexual interactions and relationships. There are also consequences for the male; his attempts to initiate sexual activity may reflect a belief that he is supposed to initiate sexual activity rather than his own sexual desire.

Issue 3: Sex Education Teaches Heterosexuality as the Norm and Ignores the Needs of LGBT Youth

The literature suggests that penile–vaginal intercourse and heterosexual relationships are the focus of most formal sex education programs at all levels. The focus on penile–vaginal intercourse provides a severely limited view of sexual expression; there are many ways to express one's sexuality and enjoy its pleasures. Providing a broader definition of “sex” would increase

choices, probably increasing the likelihood that couples (of whatever gender and orientation) will find activities that both enjoy. It would also reduce the pressure on male–female couples to engage in penile–vaginal intercourse, thereby reducing the risks associated with that activity. A focus on heterosexual activity marginalizes the experience of LGBTQ youth. It also means that such youth will receive little benefit from formal educational programs, no matter how good they are on other criteria.

Myerson (1992) suggested that these and other gender equity issues flow from a fundamental assumption of sexual dimorphism, the state of having two distinct forms within the same species. This view is the foundation for the belief that men and women are different and that the differences are natural and inevitable. In fact, decades of research and hundreds of empirical studies provide evidence of substantial similarities between boys and girls, men and women (Hyde, 2005; Chapter 2). The distributions of men and of women on almost any characteristic overlap a great deal, and there are large variations within both genders. In the realm of sexuality specifically, there are only two consistently reported differences: men are more likely to masturbate and are more tolerant of casual sexual relations. Both of these are interpretable as outcomes of our socialization and sex education of boys and girls (Hyde & DeLamater, 2006). (The difference in masturbation may be attributed to women's reluctance to report the behavior, but this is countered by the observation that women today report oral–genital contact and anal intercourse in substantial numbers; it is unclear why they would be less willing to report masturbation.)

Issue 4: Erroneous Information in Abstinence-Only Curricula Puts Health at Risk, Especially Women's Health

Abstinence-only programs leave girls and boys without adequate information about most aspects of sexual health and sexual functioning, and even worse, provide misinformation in some cases. This deprives youth of the ability to protect their sexual health, or to prevent pregnancy and STIs. A case can be made that the consequences are worse for women. In the event of a pregnancy, the woman will be carrying the fetus, and will experience the physical risks and consequences as well as many of the emotional ones. Also, many cases of STIs are asymptomatic, and may not be detected, leading to fertility problems later. It is estimated that there are 3 million new cases of chlamydia each year, most of them among young people ages 18 to 24. Chlamydia is asymptomatic in 75% of cases involving women and 50% of cases involving men (Hyde & DeLamater, 2006).

EFFECTIVE PROGRAMS THAT ADDRESS THE ISSUES

Several sex educators have turned their attention to the missing discourse of desire. Connell (2005) proposed an alternative curriculum. It would be based on a broad, holistic definition of sexual health, such as proposed by the World Health Organization, rather than prevention of pregnancy and disease. Such a definition would encompass a wide range of sexual activities

and relationships, instead of narrowly focusing on heterosexual penile–vaginal intercourse. Discussion of risk and victimization would be balanced by discussion of the positive and pleasurable consequences of sexual activity. It would recognize the normal variability in people and their characteristics, rather than treating gender differences as a biological given. The result would be a curriculum based on a discourse of desire.

In a similar vein, Allen (2004) discussed the need for a discourse of erotics. She proposed that knowledge of the body and its role in sexual pleasure, recognition of the value of sexual pleasure throughout life, and an emphasis on the practice and enjoyment of consensual, mutually pleasurable sexual relationships would characterize such a discourse. She suggested that such an educational program should be personalized to some degree (e.g., encourage each person to identify what gives him or her sexual pleasure). She suggests that such a curriculum would empower young women and liberate young men from the strictures of hegemonic masculinity.

We reviewed above the characteristics of K–12 programs that are effective in delaying onset of sexual intercourse and reducing unwanted teen pregnancy and STIs, among other outcomes. Several such programs exist and can be purchased and implemented. However, these may not resolve some of the gender equity issues. To achieve the latter, these curricula may need to be integrated with the discourse of desire or erotics as outlined above. Further, Schaalma and colleagues (2004) suggested that in order to reorient sex education programs toward sexual health, we need to incorporate models of change from the health promotion literature. Also, they urged greater emphasis on social and relationship skills as tools in maintaining and enhancing one’s sexual health. They also stated the need for well-trained educators and facilitators to implement these programs.

Turning to programming at the college level, there is a need to continue the emphasis on an interdisciplinary perspective, which is difficult in a setting that organizes instruction by disciplines. Human sexuality is one of the first areas that should be considered by initiatives to encourage interdisciplinary instruction. Another problem at the college level is the absence of opportunities for instruction for those who teach human sexuality.

Changing medical education may be more difficult. A review of data and research on women’s experiences as medical students concluded that women continue to face gender harassment and stereotyping (Bickel, 2001). Furthermore, the specialty choices of women have remained stable, meaning that they are not entering all specialties in proportion to their numbers. For example, women continue to be overrepresented in dermatology, OB-GYN, pediatrics, and psychiatry, and underrepresented in emergency medicine, internal medicine, and various surgical specialties. Gender differences in values and differential encouragement by often male faculty contribute to specialty choice. A review of Canadian medical curricula with regard to gender sensitivity in content, language, and process found some progress (Zelek & Phillips, 1997).

We reviewed the above survey data that suggests medical school training is almost exclusively focused on disease and dysfunction. Leiblum (2001) described the human sexuality course at Robert Wood Johnson Medical School. It is taught by an interdisciplinary team and emphasizes case-based and experiential learning. Leiblum described it as “a comprehensive and con-

centrated opportunity for students to become knowledgeable and comfortable” in dealing with human sexuality. The course is taught on five consecutive days, for a total of 40 hours. The article includes data from student evaluations. An appendix to the article provides an outline for the course. [AQ13]

Medical education has also been criticized for the “invisibility” of gay patients and issues in the curriculum. The course described by Leiblum includes a session devoted to these issues. A family medicine specialist at University of Western Ontario developed a gay and lesbian curriculum for postgraduate family medicine students that has been endorsed by the Canadian Medical Association (Robb, 1996). It is likely that intersex and transsexual persons are even less visible in the literature and coursework in medical and allied health schools.

CONCLUSIONS AND RECOMMENDATIONS

The biggest challenge to gender equity in formal sex education is the dominance of abstinence-only sex education in K–12 education in the United States. This dominance is largely driven by federal funding and other policies and practices that cater to a small, vocal, unduly influential minority of Americans.

The American Foundation for AIDS Research (2005) stated:

In summary, the scientific evidence does not support the U.S. government’s current policy of making abstinence-only-until-marriage programs the cornerstone of its HIV prevention strategy for young people. Nor does it support the rapid scale-up of resources to promote abstinence-only-until-marriage programs in the U.S. and globally. Rather, the scientific evidence to date suggests that investing in comprehensive sex education that includes support for abstinence but also provides risk-reduction information would be a more effective HIV prevention strategy for young people.

Numerous professional organizations are calling for comprehensive sexuality education programs to deal with the public health crises associated with adolescent sexuality. These groups include the American Academy of Pediatrics (Klein, 2005), American Medical Association, National Education Association, National School Board Association, National Parent–Teachers Association, and Society for Adolescent Medicine (2006). [AQ14]

Under the circumstances, continued investment in abstinence-only programs can be challenged on both financial and ethical grounds: [AQ15]

- It is fiscally irresponsible to spend millions of dollars of taxpayer’s money to support ineffective programs. This is especially true in a time when there are huge budget deficits at both federal and state levels.
- It is unethical for educators to withhold information from millions of young people that would give them the knowledge they need to make informed, responsible decisions about their bodies, and the information and means to prevent pregnancy and sexually transmitted infections.

Overall, sexuality educators, parents and everyone else concerned with the health of adolescents and adults should protest the use of another dollar to support ineffective sex education

programs in our public schools and communities. Instead we should press for accurate, balanced, gender-neutral, non-heterosexist sexuality education for every adolescent—education that recognizes the spiritual and mental components as well as the physical ones.

At the college level, everyone directly or indirectly involved in sexuality and health education should encourage change in sexuality courses. We should search for and utilize materials that are interdisciplinary, focused on health as well as prevention of illness, and give appropriate attention to the social construction of gender and the similarities in women's and men's interpersonal and sexual functioning.

Finally, to meet the demand by patients (i.e., ourselves) for informed medical professionals, we should express our concern to medical school administrators and faculty about the non-existence or narrowness of existing curricula concerned with sexuality. There are models of courses that are comprehensive, focused on health, and pay appropriate attention to the variety of sexual relationships and lifestyles in the contemporary North American societies.

The barriers to accomplishing these goals were articulated by Klein (1992) as silence, confusion, and disunity. We have certainly made headway in giving voice to the problems created by the formal sexuality education practices of the early 21st century,

as evidenced by many of the citations in this chapter, and the list of organizations supportive of comprehensive sex education. We have also made progress in eliminating confusion. Valid, reliable evaluation data are increasingly available showing clearly what works and what does not work, much of which are referenced in these pages. The most serious barrier today may be disunity; we still are not speaking with a unified voice to stakeholders, media representatives, policymakers, politicians, and school teachers and administrators. Too often we stand by when a sex educator working for the principles we share is attacked by those who object to providing accurate, comprehensive information to students. It can be hoped that the scrutiny given these issues by reviews such as this will increase our resolve to stand together in the face of attacks by people who seem to prefer to see young people become ill and die than to “tell it like it is.”

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