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**Sexuality Education in the Twenty-First Century:
The Struggle over Adolescent Rights**

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A nation's sexuality education curriculum reveals its broader attitudes towards sex, sexuality, and sexual health, and how it chooses to educate its citizens about these fundamental elements of human life. Although it may appear to be a private concern, a person's sexuality has strong implications for his or her status in society as either a model or a marginalized citizen. Sexuality education reflects social, cultural, political, and governmental concerns that evolve into standards for sexual behavior. When "school boards, teachers, young people, parents, and legislators argue over whether, what, and when young people should learn about sexuality in school, they are also... helping to define 'good' sexual citizenship by delineating which sexual desires, behaviors, and identities confer the rights and responsibilities of belonging, and which preclude full, legitimate citizenship" (Herdt and Howe 32). The current debate over sexuality education centers on two competing ideologies and curricula: abstinence-only and comprehensive education. Abstinence-only education restricts sexuality to a heterosexual, married, monogamous definition and sets rigid parameters for sex and sexuality; comprehensive sexuality education acknowledges the reality of premarital sex, accepts it, and prepares adolescents for life as sexually active people.

Adolescents are human beings that exhibit sexual curiosities and desires, making the role of sexuality education, in part, to help them make sense of those feelings. Contemporary adolescents identify sex to such a strong degree with adulthood and independence that it has become the quintessential steppingstone to achieving the autonomy that they represent (Burtney and Duffy 12). The call to educate the world's youth at an earlier age and to increase both the content and the quality of their education has become more urgent. Internationally, the gap between the average age of marriage and the average age of first intercourse has increased (xv). As a result of this divergence, the period of sexual exploration and experimentation before legal commitment to a monogamous relationship will last about 14 years (xvi). While this statistic only highlights an average length of time, whether that gap manifests as one year or fourteen, the nature of the need for education is still imperative: any length of time marked by ignorance presents risks to the livelihood of adolescents, and consequently the health and stability of the society-at-large. It is vital that sexuality education prepares adolescents around the globe for this period of self-discovery, no matter how long it is. Sexuality education should prepare individuals in adolescence to apply lessons learned about sex, sexuality, and sexual health during this period of development and into adulthood.

The dominant sexuality education pedagogy, though, insists that if adolescents become informed about their bodies, harm will be the end result. But shielding our youth from the truth only places them in "a perilous state of *ignorance* rather than *innocence*" (Goldman 421). Knowledge about one's body has been distorted to equate danger, despite the fact that "knowledge is the best protection, just as children are taught information, awareness and practical skills about road safety so that they will keep away from traffic" (Goldman 421). Those in charge of sexuality education (legislators, school boards, and teachers) have instead stripped sexuality education of the bulk of its content, leaving adolescents with limited or distorted knowledge. This inversion positions youth to enter the adult world without authentic or practical information about their bodies and sets them up to lead *unhealthy* sexual lives.

In a perfect world, the process of sexuality education would lead to a realization of each point of the definition of sexual health provided by the World Health Organization (WHO):

a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (Herdt and Howe 89).

Intertwined with the concept of sexual health is sexual literacy, defined by the WHO as "the ways in which people become knowledgeable and healthier sexual beings – protecting themselves from

HIV/AIDS and STIs, avoiding unintended pregnancy, and understanding sexual violence such as date rape” (Herdt and Howe 3). A young child cannot learn to read a book without first learning the alphabet; likewise, an adolescent cannot be sexually healthy if he or she has low sexual literacy. School-based sexuality education best enables adolescents to become sexually literate, primarily because schools have systematic organization, prioritization, and dissemination of information and typically reach the most youth (Weaver, Smith, and Kippax 173). National governments traditionally have a central role in either creating standards for sexuality education in schools or the actual curriculum itself.

However, federal involvement in sexuality education curricula design is particularly risky because it exposes sexual health to competing political interests; this shift from objective science to partisan politics has caused sexuality education in the 21st century to deteriorate (Herdt and Howe 3). Subjective interpretation of science creates a social hierarchy in which anything that deviates from heterosexuality, monogamy, and sex within marriage is considered a detriment to oneself and incompatible with the objectives and morals of society (Fields and Hirschman cited in Herdt and Howe 32). By transposing religious and cultural values onto the science of sex, sexuality, and sexual health, it ceases to be science anymore. The tension between religion and science manifests in the conflict between abstinence-only and comprehensive sexuality education, two mutually exclusive ideologies and curricula.

Comprehensive sexuality education is the most effective way of ensuring adolescent sexual health that meets the World Health Organization’s standard, while abstinence-only education fosters ignorance in youth and leads to diminished sexual literacy as defined by the WHO. The Netherlands, the United States and Uganda each provide a distinct snapshot of the spectrum of sexuality education; each nation’s respective triumphs and pitfalls reveal that comprehensive sexuality education is vital to addressing the critical issue of adolescent sexual health in the twenty-first century. Because The Netherlands is the closest of these three countries to meeting the WHO’s standards for sexual health and sexual literacy among its youth, it has earned the distinction of having the most effective model for sexuality education among developed nations. The blurring of church and state in the United States, on the other hand, has caused the federal government to codify subjective beliefs on sexuality education that defy science and deny knowledge to adolescents. Religious interpretations of sex, sexuality, and sexual health have been amplified to carry the force of law. Paralleling this gap between government policies and adolescent needs, Uganda’s sexual health infrastructure too closely reflects its sexist, heterosexist, and conservative-Christian culture, preventing adolescents – particularly adolescent girls – from protecting and educating themselves sexually. This country’s best option for implementing comprehensive sexuality education is informal education that counteracts cultural prejudices, but is built upon cultural practices. The comparative analysis in this paper will comment on how abstinence-only sexuality education is poisonous to the global state of health, in addition to the causal relationship between comprehensive sexual education and improved adolescent sexual health. The method of comparison includes discussion of quantitative health statistics, qualitative interviews, and discussion of the perspectives of adolescent agency that inform sexuality education in The Netherlands, the United States, and Uganda.

The Gap between International Goals and Implementation

Before examining the state of sexuality education in The Netherlands, the United States, and Uganda, it is important to analyze the institution that provides the global standards for sexual health and sexual literacy: the World Health Organization (WHO). The WHO is an international leader in tackling global health issues such as the HIV/AIDS epidemic and improving sexuality education standards globally. However, a particularly Western perspective sometimes narrows the WHO’s potential to affect global sexual health, as it neglects to account for cultural variables that prevent a policy from working in a *developing* nation, despite the fact that it may have worked successfully in a *developed* nation.

The WHO should be applauded for consistently reevaluating programs, standards, and guidelines for sexual health; it even included aspects of sexual health in its Millennium Development Goals. Still, it must be noted that in 2011, many countries with restricted finances still have not implemented guidelines from 2006 (Walensky 2). Third World countries such as Uganda had to meet increased expectations for

health with limited resources, low funds, and few personnel, the combination of which severely reduced the possibility of achieving the WHO's goals. The WHO does not fully bridge the economic gap between rich and poor nations, allowing economic disparities to hinder the success of health programs. For instance, the WHO presumes that health organizers will have access to patients before a disease such as HIV/AIDS advances too far to be treated properly, although late presentation to health workers is endemic to rural communities (Walensky 10). In a similar vein, the cost of implementing new guidelines – let alone maintaining them – severely restricts the ability of poorer nations to abide by them. The WHO does not properly consider whether these countries can afford to construct, staff, and fund new and expanded labs to accommodate earlier and expanded treatment. Although the WHO has praiseworthy goals and ideas, the feasibility of those goals and ideas in Third World countries seems to be an afterthought; a Western approach to handling disease in a Western country will not automatically mesh with the environmental, economic, and governmental conditions of a Third World nation like Uganda.

This issue of culture-specific program design and implementation is the crux of the WHO's problem of perspective. Although *global* standards for sexuality education curricula seem appropriate, expedient, and efficient, Antal *et al.* notes that there are scholars who “suggest that since every culture has its own norms and values, it is impossible to apply policy lessons that have been learnt” in one country to another country (Burtney and Duffy 36). In Uganda, for example, attention should be focused more on the informal system of sexuality education than the school system, because the latter reaches less than a majority of adolescents. Instead of bolstering abstract Western definitions and standards, the international community should focus on improving the health services that will supplement sexuality education. Alison Housie writes that “confidentiality, opening times, visibility of a service (to parents/family), friendly services, positive professional attitudes are all key factors in young people's willingness and perceived ability to access sexual health services” (Burtney and Duffy 65). If the WHO can ensure the aforementioned aspects of health services (as opposed to simply injecting blanket health policy guidelines into international discourse), then its global standards can be met by more nations.

Once nations receive these guidelines, though, further problems can arise depending on how international aid organizations categorize and prioritize health issues. Historically, the implementation strategies to combat HIV/AIDS have not complemented by or integrated with one another. As a result, scattered disease-prevention systems have been at risk of becoming stalled or redundant, undermining the potential for higher-quality results associated with unified policy initiatives (Germaine 841). When divided and placed into separate agendas, sexual health issues (i.e. HIV/AIDS) cannot be dealt with effectively because the funding, data, publicity, and overall fight against the individual issue are disjointed. Even if categorized properly, a disease can still remain unchallenged depending on the method for handling it. For instance, since its creation in 2002, The Global Fund to Fight AIDS has taken an unsustainable “vertical approach to disease control rather than a horizontal approach to building health-system capacities. Most of its HIV/AIDS money went into treatment,” not prevention programs or research (Germaine 842). The key to fighting diseases is to find effective ways to prevent contraction, rather than continually treating the symptoms. Global health leaders need to reevaluate the prioritization of sexual health issues and emphasize the need for prevention over treatment alone so that the cycle of continually treating symptoms can be broken (Germaine 842).

To reiterate, the World Health Organization provides international coordination to amass information about diseases, design prevention and treatment strategies, and create standards for the intentional community. Despite the high caliber of its work, the WHO is nonetheless negatively impacted by its Western perspective, its lack of culture-specific variants of standards that are more realistic for impoverished nations to achieve, and an inability to effectively prioritize and group similar problems together to increase efficiency and effectiveness of fighting diseases. But, similar to issues with sexuality education curricula, the WHO's setbacks can be rectified.

The Netherlands: Empowered to be Healthy

The Netherlands is one of the few countries in the world that meets the WHO's standards for sexual health and sexual literacy, primarily because of the nature of its sexuality education, which includes one of the most comprehensive approaches in the world (Ferguson, Vanwesenbeeck, and Knijn 94). Sexuality education in The Netherlands has been mandatory in schools since 1993. According to the Health and Education Board for Scotland, although there is neither a topic labeled "sex education," in 2001 almost 100% "of secondary schools and 50% of primary schools include[d] sexuality information in their curriculum" (Weaver, Smith, and Kippax 174). In mandating that it be taught in schools, The Dutch government has ensured that nearly all adolescents in The Netherlands will receive a comprehensive sexuality education. The state recognizes the value of honest information about one's body and has used the education system as a conduit to expose as much of the adolescent population to that knowledge as possible, supplementing though not necessarily supplanting at-home sex education.

Teachers who will educate adolescents about sex, sexuality, and sexual health are trained by The Netherlands Institute for Health Promotion and Disease Prevention and usually include sexuality education in Biology classes. Required topics of discussion include pregnancy, sexually-transmitted-diseases and -infections, the spectrum of sexuality, homophobia, in addition to "value clarification, respect for differences in attitudes, and skills for healthy sexuality" (Greene, *et al.* cited in Weaver, Smith, and Kippax 174). These latter components help students to think critically about sex and to see it as an aspect of their lives that deserves attention and discussion. Because teachers acknowledge sexual identity and sexual orientation as legitimate topics, students receive information about heterosexuality, homosexuality, and even bisexuality (Ferguson, Vanwesenbeeck, and Knijn 100). The inclusion of these topics helps prevent the alienation of LGBT (Lesbian, Gay, Bisexual, and Transgender) adolescents. The Dutch government has taken an "empowerment" approach to educating adolescents about sex, sexuality, and sexual health; it supplements the comprehensive class-based education by providing educational material to parents, doctors, and media outlets (Weaver, Smith, and Kippax 174-75).

The Netherlands challenges the assumption that educating students about sexuality will automatically cause them to engage in sex; adolescents in this nation are among the most sexually-healthy in the world in terms of rates of STDs, STIs, teenage pregnancies, and abortions (Weaver, Smith, and Kippax 182). They attain this high level of sexual health *and* understanding because of the comprehensive nature of their sexuality education curricula and their liberal attitudes towards adolescent sex and sexuality. Dutch youth are expected to apply the classroom lessons to their lives, to be active learners who see the value of sexuality education to their health.

The Dutch have also implemented a government-supported and -funded program for high school students called Long Live Love that arose from a collaborative "needs-assessment process" that included input from students, teachers, focus groups, and stakeholders (Ferguson, Vanwesenbeeck, and Knijn 101). Long Live Love is comprised of 6 lessons that include 30 learning activities, aimed at lower secondary schools that teach students ages 13 to 15, and also includes a teacher's manual, student magazine, and an accompanying video (Wiefferink 324). Teachers are also given alternative curricula to utilize if certain material evokes immature reactions from the students. Although Long Live Love is a national curriculum and sex education strategy, it has *regional* implementation on the school-level (Wiefferink 325). A key feature of the national curriculum is its flexibility to be revised and updated. First enacted in 1993 and revised in 1999, Long Live Love has since yielded improved results: "students who received lessons using the second version reported a greater increase in knowledge, more liberal attitudes toward homosexuality, and increased ability to communicate their sexual wishes and boundaries" (Ferguson, Vanwesenbeeck, and Knijn 101). The Netherlands realizes that educational curricula should be progressive and develop with feedback from appropriate research, facts, and culture in order to truly benefit adolescent students.

A case study of the revision of the Long Live Love sexuality education curriculum and a teacher training session reveals further benefits of the Dutch model. Participants in the study included 109 teachers from 77 schools of lower secondary education who taught in either urban or rural locations. Teachers took part in sessions designed to update their knowledge about sex, sexuality, and sexual health;

improve their confidence in handling the subject matter in adolescent classrooms; and reinforce the benefits that this education offers to their students beyond the classroom (Wiefferink 328). About ninety-three percent of the teachers taught Biology and/or Care (a home economics and health education class), while more than seventy percent had never been part of a sexuality education “refresher course” (Wiefferink 328). The overwhelming lack of experience with this type of educational strategy allowed the effects of the course to be more visible.

The most important factor in determining how much of the curriculum teachers implemented was whether or not the individual teacher believed in the practicality of the material in reference to students’ lives (Wiefferink 329). The intervention program had “a significant positive impact on their curriculum-related beliefs, especially on their outcome beliefs, subjective norms, perceived social support and self-efficacy” (Wiefferink 330). This result is notable because prior to the training, the intervention group held identical beliefs about the curriculum as the control group, which did not receive any refresher course. An additional benefit of the teacher-training program was improved teacher confidence, a quality that allows them to effectively discuss sex and sexuality with adolescents who may find the material funny, embarrassing, or strange (Wiefferink 330). An important consideration with which to contextualize this study is that all of the teachers volunteered, which may have produced a bias; for instance, they may all have come from schools with good sexuality education policies already in place (331). The authors conclude, though, that the intervention program managed to improve the quality of sexuality education in the Dutch classrooms studied (Wiefferink 323).

In addition to teacher confidence, attitudes, and beliefs in the applicability of the curriculum, the multimedia materials used to supplement the verbal lessons contribute to either the success or the failure of sexuality education. The thoroughness and openness of these materials in The Netherlands reveals its commitment to comprehensive sexuality education. For instance, one booklet includes “reproductive health terms such as sperm, ejaculation, orgasm, and menstrual cycle [that] are defined alongside labeled illustrations of the body and sex organs... Another booklet for 11 and 12 year olds includes a section called ‘this is how you have sex’ consisting of four illustrations, each with an accompanying description” (Ferguson, Vanwesenbeeck, and Knijn 99). Some may call this type of educational material pornography, but in fact, “pornography is legally defined as that which is calculated to corrupt and deprave,” while the sexuality education materials are designed “to educate, inform and enlighten” (Goldman 432). The Dutch employ these materials to teach adolescents about sex and sexuality, not to corrupt them.

Although it may seem radical to suggest that elementary school students should be learning about sex, sexuality, and sexual health, they have the capacity to understand the material maturely. As abstinence-only education shows, we all too often underestimate the intellectual abilities of our youth, such as when adolescents on the cusp of adulthood are denied information about condoms and birth control. To that effect, research on The United States, The United Kingdom, Canada, Sweden, and Australia has found that

...while many children in many countries are ignorant about important sexual matters, those who have received systematic sexuality education are capable of understanding at five to seven years old how babies begin; pregnancy and birth; sex differences between girls and boys, and between men and women; and about 100 other sexuality topics. Nine to 11 year olds are capable of understanding about male and female sex organs, conception and contraception, and the basis of love for human relationships. Only two areas of sexuality appear to be too difficult to comprehend before adolescence; namely, the genetic determination of sex, and the more complex details of gestation and birth. In fact, many adults find these two areas difficult to understand. Swedish children, having had compulsory school sexuality education since about seven years of age, showed a much earlier and more complete grasp of these matters (Goldman 427).

Youth, then, can effectively understand sexuality education that is comprehensive. The Dutch have acknowledged this fact, designed a curriculum around it, and as a result their adolescents have lower rates of STDs, STI's, teenage pregnancy and abortion than most of the developed world.

The government in The Netherlands trusts its youth to maturely handle and then apply their sexuality education. Adolescents are given extensive preparation for the reality of life as sexual adults. Students are educated not only about "where to buy condoms, what to do if [they] are nervous or embarrassed about buying condoms, and... how to use a condom," but also "where to obtain [oral contraception], situations when its effectiveness is compromised, and tips on how to remember to take the pill" (Ferguson, Vanwesenbeeck, and Knijn 100). The Dutch believe that adolescents can be knowledgeable sexual actors if they are in a relationship and use contraception (104). Youth are not told what to do, but rather are encouraged to think critically about what *they* want from sex, and to talk confidently about those desires to their partners (99).

Adolescents are instilled with a three-pronged message pertaining to sex, sexuality, and sexual health: "birth control provides the best protection against pregnancy, the pill does not protect you from STIs, and a condom offers the best protection against STIs. These three messages unite to form one overall recommendation: if you have sex, use a condom and the pill together, commonly referred to as the Double Dutch method" (Ferguson, Vanwesenbeeck, and Knijn 100). Sexuality education teaches preparedness in sexual relationships, but does not rule out the potential need for abortion: in fact, the government will pay for an abortion performed in a Dutch clinic, while national or private insurance will pay the fees for those done in hospitals (68).

Surprisingly, The Netherlands' open attitude towards sex, sexuality, and sexual health is relatively new. Before the "sexual revolution" of the 1960s, The Netherlands did not support family planning or abortion, and rarely provided sexuality education for students (Burtney and Duffy 85; 67). Although it had an attitude towards sexuality education that very closely mirrors the United States today, The Netherlands has since progressed. Of the three countries analyzed in this paper it is the closest to meeting the WHO's definitions of sexual health and sexual literacy. Nearly "one-half of teenagers 15-19 years of age in The Netherlands and in the United States have had sexual intercourse. Likewise, slightly more than one-half of teenagers in both countries have experience with oral sex. Roughly 11% of males and females 15-19 years of age in The Netherlands and the United States have had anal sex" (Ferguson, Vanwesenbeeck, and Knijn 97). These results show that teenagers in the United States and The Netherlands are engaging in sexual activities at parallel rates, irrespective of the sexuality education they receive. However, Dutch adolescents are more educated about the biological *and* emotional aspects of sex. They also have a government and a national mentality that supports their right to choose to have sex, receive accurate information about sex, and purchase medical devices to help achieve good sexual health. The cooperation of these factors has enabled Dutch youth to be more knowledgeable about sex, sexuality, and, sexual health than adolescents in most of the world.

The United States: Regression to Ignorance

A direct comparison between the United States and The Netherlands reveals a striking disparity that warrants further inquiry into how these two countries teach sexuality education. Compared to The Netherlands, the United States has 8.5 times the number of births to adolescents ages 15-17 and its adolescents are: 3 times more likely to contract HIV, 6 times more likely to get syphilis, 8 times more likely to get an abortion, and 74 times more likely to get gonorrhea (Weaver, Smith, and Kippax 179). The most recent adolescent fertility rate data since 2000 shows that the United States reported a rate of 41 live births per 1000 adolescents, while The Netherlands reported only 4 per 1000 (WHO Millennium Development Goals 1). Nine years later, the United States still had the highest adolescent birth rate in the entire developed world (Centers for Disease Control and Prevention 1). Adolescents in The Netherlands are more likely to use both a condom and the pill when having sex, while adolescents in the United States are more likely to use neither method at all (Ferguson, Vanwesenbeeck, and Knijn 97). The Netherlands has clearly excelled in the quality of the sexual health of its adolescents, while the United States struggles

on the same front. The factor that most clearly links the divergent paths of adolescent sexual health and literacy in The Netherlands and the United States manifests most clearly in the methods of sexuality education in both countries.

Sexuality education in the United States is overwhelmingly one-sided; in 2002, The Centers for Disease Control and Prevention reported “that 92% of middle and junior high schools and 96% of high schools taught abstinence as the best way to avoid HIV and STIs” (Kubicek *et al.* 244). The term “abstinence education” acts as an umbrella for two subtypes: abstinence-plus and abstinence-only. Abstinence-plus acknowledges the benefits of contraception, but stresses abstinence as the best option for teens, while abstinence-only either silences any discussion of contraception or focuses only on its failures, describing abstinence as the *only* option for teens (Weaver, Smith, and Kippax 177). Sexuality education in the United States manifests almost exclusively in the form of abstinence-only education, a whitewashed incarnation of scientific evidence manipulated to support moral beliefs in purity, monogamy, and heterosexuality.

Although abstinence-plus includes discussion of birth control and acknowledges the potential for adolescent sexual relationships, the portrayal of adolescent sex remains fixed in negativity: abstinence is still seen as ideologically greater than premarital sex, when such judgments are in fact subjective. Essentially only nominally different, both types of abstinence education aim to teach children that premarital sex and teenage pregnancy are “against social standards and harmful to individuals, children, parents and society (Sonfield & Gold)” (Weaver, Smith, and Kippax 177). At the conclusion of either version of abstinence education, students leave with the impression that abstinence is the proper way to stay sexually healthy, and that the choice to be sexually active somehow violates both their education and society’s standards.

The United States federal government has codified the abstinence-only perspective of sexuality education into law, creating a legal impasse for comprehensive sexuality education in the process. In 2006, the United States Congress offered its own definition of “abstinence education,” solidifying its place in formal education through national legislation. Congress defines abstinence as an approach to teaching sex and sexuality that:

A: has as its exclusive purpose teaching the social, psychological, and health gains to be realized by abstaining from sexual activity; B: teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children; C: teaches 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: teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of sexual activity; E: teaches that sexual activity outside the context of marriage is likely to have harmful psychological and physical effects; F: teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society; G: teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and H: teaches the importance of attaining self-sufficiency before engaging in sexual activity” (Fields 9).

This definition very clearly rests on the assumption that abstinence-education equates abstinence-only education; it neither explicitly states nor implies the existence or use of condoms, oral contraception, abortion, or family planning services. Its implementation also includes an unstated provision that makes it illegal for teachers to discuss benefits of these options for adolescents. To restate its core value and standard: safe sex means no sex.

The scholarly definition of abstinence education, however, undercuts both the sanctity and legitimacy of abstinence education. Education and health scholars classify abstinence as “an educational policy largely bereft of scientific credibility” (Herdt and Howe 8) rooted in “conventionalized morality that denies accurate knowledge to the young people who need it, and marginalizes others” (Herdt 17-18). In short, it hardly qualifies as “education” at all.

Abstinence education has continually been proven to be ineffective: its curricula fail to teach accurate information, change how adolescents understand sex, and prevent premarital sex (Kubicek *et al.* 257). A 2004 study reported that eleven reviews of abstinence-only sexuality education revealed minimal signs of changing how adolescents view sex or their desire for it (Hauser cited in Kubicek *et al.* 244). Ironically, but not unexpectedly, “almost all adolescents who pledge to remain virgins until marriage break those vows, and they are much less likely than non-pledged adolescents to use condoms or seek treatment for STIs when they do have sex” (Goldman 424). These same adolescents also engaged in oral and anal sex at much higher frequencies, assuming that non-vaginal sexual activities would keep their virginity intact (Goldman 424). The data suggest that adolescents who receive abstinence-only education not only engage in premarital sex, but also do so without knowledge of how to protect themselves from STDs, STIs, or unwanted pregnancy.

Although Congress crafted a national definition of “abstinence education” and openly endorses it as the best method for teaching sexuality education, the U.S. government is not officially allowed to implement any standard for state and local school curricula (Weaver, Smith, and Kippax 176). As a result, there are no laws mandating that sexuality education has to be taught and the majority of school districts are implementing the national standard on their own. Although this process works in The Netherlands, many states in the United States have assumed too much power to deviate too far from any type of national standard. A late 1990s survey found that 31% of school districts left sex education policy implementation to the discretion of the schools themselves or even the teachers at the schools, and only 14% had comprehensive sexuality education programs (177). One effect of this free-for-all approach to sexuality education is that the United States is one of the few developed nations that does not begin sexuality education in primary school (178). By prolonging the period that adolescents remain ignorant of sex, sexuality, and sexual health, the United States’ approach to sexuality education actually endangers youth. Although the autonomy of the states seems to counteract the conservative stance of the national government, the majority of states mimicked the national government’s support of abstinence education. This division of power presents a risk should the latter shift its support towards comprehensive sexuality education and attempt to impose a national curriculum in the United States.

Abstinence education first arose in 1981 with the passage of The Adolescent and Family Life Act. This subjective policy “awards grants to public and non-profit organizations to provide services to prevent ‘premarital sexual relations and adolescent pregnancy,’ as well as [to] support pregnant young people and parents” (Burtney and Duffy 83). President George W. Bush reaffirmed federal commitment to this point of view by supplying abstinence-only policies with \$135 million in federal funding, a 3000% rise in funding between 1996 and 2001 (Burtney and Duffy 84). The second federal policy to deal explicitly with sexuality education is Title V Section 510 of the Social Security Act (1996), which fostered an official federal endorsement of the abstinence-only approach to sexuality education. In 2003, President Bush supported the Personal Responsibility, Work and Family Protection Act, which provided \$200 million annually to promote marriage and \$50 million to promote abstinence. His administration went even further and tampered with the Centers for Disease Control and Prevention’s website by eliminating all information about condoms and ways to prevent adolescent pregnancy (Berer 9-10). These actions culminated with the international censoring of medical information through the Mexico City Policy (the “Global Gag Rule”) in 2006. While in effect (it was repealed by President Obama in 2009) it blocked any U.S. funding to family planning services abroad that discussed abortion or advocated for it (Herdt 12). Even the use of the word “abortion” constituted grounds for elimination of all funding,

Locally, abstinence education policy emerges in the form of Community Based Abstinence Education (CBAE); in 2006, the U.S. Department of Health and Human Services proposed to spend \$115 million through the CBAE program to promote abstinence-only education. Four states have refused to accept federal funding for it: California, Maine, New Jersey, and Pennsylvania. Still, the remaining 46 states have accepted federal funding for abstinence-only curricula and enacted them in schools (Fields 12). This conservative view of sexuality education was nationally-defined and -endorsed, adopted on the state-level as a legitimate policy that comes with funding, and implemented on the local level as a tool for

instilling morals in young people. At every level of government, abstinence education has found strong footing.

The abstinence-only ideology gains political and social strength by feeding off of Christian dogma, its origins. Rather than employ an objective, factually-based approach to legislation, the federal government has aligned itself with fundamentalist Christianity (Berer 10). The Bible has inherent recognition by fundamentalist Christians as “a divinely authored book of scientific truths”, whereby any attempt to disprove these truths is both blasphemous and moot (Hughes 143). Even in the face of scientific evidence, devout Christianity will maintain that the Biblical interpretations of biology, physics, and history contain more truth. Contemporary fundamentalist Christians have “a tendency to divide the world into good and evil... a profound distrust of pluralism, an inability to deal in meaningful ways with complexity, nuance, or ambiguity, and a deep suspicion of many of the findings of modern science” (Hughes 153). The ability for religion and science to work cohesively is restricted by the fact that the two have contradictory epistemological foundations.

Unlike religious truths, modern science relies on research, progress, and the ability to correct a wrong hypothesis; comprehensive sexuality education draws its data, perspectives, and refinement from these similar values. It is a cumulative discourse and allows for knowledge to grow. For instance, the way we teach biological science has not remained stagnant over the last century: it has evolved with new research and conclusions. Sexuality education, which comprises biological facts about the human body, sexuality-transmitted diseases and infections, and sex – the most primal and biological of functions – should be a similarly cumulative and progressive subject. Abstinence-only education may teach the biology behind puberty, but not how those physical and mental changes will play out “in the context of... relationships, emotions, expectations, and vulnerabilities” (Fields 112). The holes in abstinence-only policies “contribute to a broad effort to scapegoat the most vulnerable members of our society – young people, people of color, low-income people, and lesbian women, gay men, bisexual, transgendered, and queer (LGBT) people – as the causes of various social ills” (Fields 165). Sexuality education not only needs to diversify its content, but also its portrayal of those who engage in sex, question their sexuality, and care about their sexual health.

For gay and bisexual men in particular, sexual health problems have worsened: in 2008, the Centers for Disease Control and Prevention reported that these men continue to display high rates of HIV contraction that do not show signs of decreasing (Kubicek *et al.* 244). Additionally, the results of a 2001 Massachusetts study of sex education “found that LGB [Lesbian, gay, bisexual] youth were less likely than heterosexual youth to report having received information about HIV or instruction related to condom use. However, in the same study, LGB youth who received gay-sensitive HIV curricula and materials were less likely to engage in sexual risk behaviors” (Kubicek *et al.* 244). This finding reveals the staunch importance of including information that pertains to LGBT (Lesbian, Gay, Bisexual, Transgender) individuals in sexuality education. Without this information, LGBT youth are defenseless as sexual actors, but when given education that directly connects to their lives, they have the capacity to engage in safe sex or to confidently abstain.

In 2008, the Healthy Young Men (HYM) study revealed how sexuality education today impacts young men who have sex with men. Participants in the HYM study were young men ages 18 to 24 living in Los Angeles County for at least 6 months, who self-identified as gay, bisexual or unsure, are Caucasian, African American, Latino, or of Mexican descent, and who reported having had sex with a man (Kubicek *et al.* 246). Seventy-seven percent of the men in the study identified themselves as gay and fifteen percent as bisexual; most did not learn about STIs until high school, where the curriculum focused on vaginal sex and remained in the context of heterosexual relationships (Kubicek *et al.* 247-48).

Respondents in the HYM study identified that “gay sex” typically came up in classroom discussions “if someone in the class asked a question or made a comment – and that these questions were usually met with laughter from their peers. In this environment, most reported that it would have been difficult to actually ask a question about anal sex or anything related to homosexuality” (Kubicek *et al.* 249). Even though the young men reported that they learned how to put on condoms in class, they were

not taught *why* condoms were necessary to maintain good sexual health (Kubicek *et al.* 249). Not one of the participants said that his parents addressed the possibility of same-sex attraction or sexuality (Kubicek *et al.* 250), indicating that formal sexuality education cannot always rely on parents to thoroughly educate their children about sex, sexuality, and sexual health. Cooperation between these two channels of education is necessary for the improvement of sexuality education in the United States and abroad.

Experimentation with sexual activities was a source of knowledge about sex for many participants, who often described it as “awkward” and “weird” because schools were providing information about sex too late for them (Kubicek *et al.* 254). The study indicated that “it was not unusual for young men to describe early sexual experiences... at the age of 7 or 8” (Kubicek *et al.* 254). At such a young age, most of the young men did not even know about various types of sexual activities, including anal sex, until they had engaged in it. Pain was not unusual for their first sexual encounters, and one described it as feeling “like an axe” (Kubicek *et al.* 255). Apart from physical pain endured during sex because of lack of knowledge of appropriate preparation, these youth also experienced mental subjugation. Their inexperience caused them to submit to older partners with more sexual experience (Kubicek *et al.* 254). Legally, the experiences described by each participant amount to statutory rape, even though none of the participants in the study considers himself a victim of rape (Kubicek *et al.* 258). The responses in the study do not describe every young man who has sex with men, but they do reveal prominent risks associated with lack of sexuality education and apprehension to talk openly about sex and sexuality.

The combination of low sexuality education and the pain of the first sexual encounter led many participants to question not only their sexual identity, but also their self-worth (Kubicek *et al.* 256). Silence on the topic of homosexuality gives LGBT youth no reason to pay attention in sexuality education classes that are strictly about heterosexuals. Their experiences reveal that what we say – and, just as important, what we *don't* say – matters in sexuality education. There are two types of curricula that students experience in a classroom setting: the formal and the hidden. The formal curriculum can be described as state education standards, curriculum approval at the local level, lesson plans for classrooms, and materials used in conjunction with the lesson plans (Fields 71). The hidden curriculum, on the other hand, contains the more subliminal lessons that students receive and engage-in during class (Fields 71-72). For example,

teachers may let homophobic jokes go without reprimand, or they may even make these jokes themselves. Such practices offer students important lessons: people in positions of authority legitimately hold lesbian, gay, and bisexual desires, identities, and behaviors in contempt; and lesbian, gay, bisexual, and queer people cannot count on those with authority to protect students who do not conform to conventional gender and sexual expectations (Fields 72).

Tolerance of homophobia is only one example of the many loopholes that exist in abstinence-education that leads to ignorance as opposed to knowledge of sex, sexuality, and sexual health. Adolescents need an educational environment where they can expect to ask questions, receive informed answers, and become prepared sexual actors. At this moment, the United States does not offer enough youth this opportunity.

Uganda: Entrenched in Hierarchy

While LGBT adolescents may be the most neglected in the United States' sexuality education curricula, in Uganda almost all adolescents suffer from a heterosexist education and have severely restricted outlets for receiving accurate information. The parallel between these two nations exists primarily in their conservative attitudes towards sex, sexuality, and sexual health. However, conditions for adolescents are much worse in Uganda. Its ranking on the human development index (HDI) is lower than the average for all of sub-Saharan Africa, and it is considered one of the most underdeveloped countries in the world (Knudsen 40). Uganda's fertility rate is higher than most of the world: each woman gives birth to approximately 9 children. (Knudsen 40). Sexism and fertility are very closely related in this

country, where couples typically continue to procreate until they have the number of male children they want (Knudsen 41).

This sexist culture spills over into the general sexual health of the population. Patriarchal attitudes in Ugandan social structures prevent women from maintaining good sexual health to a much greater degree than men (Mirembe 291). Sexism in Uganda not only subordinates women within marriages, but also infiltrates the school systems with the effect of reinforcing gender roles. Sexual violence, like sexual ignorance, stems from gender inequality and needs to be addressed. One “study of secondary-school students in Kabale found that 31 percent of girls and 15 percent of boys reported being coerced into having sex,” while another study found that 14% of 15-19 year old girls who had engaged in sexual activities said that they felt coerced into losing their virginity (Knudsen 42). The girls in this statistic were not only more likely to forgo condom use the last time they had sex, but were at a greater risk for unwanted pregnancies and contraction of a sexually transmitted infection (Knudsen 43). Almost “half of all eighteen-to-nineteen-year-old women have had a baby, and another 16 percent are pregnant at any given time” (Knudsen 42). These women are adolescents who have been denied the right to information about sex, sexuality, and sexual health that could improve their ability to decide whether or not be in a relationship, to have sex, or to have a baby.

Gender equality is a pillar of comprehensive sexuality education that meets the World Health Organization’s standard for sexual literacy, so when this education is implemented within a gendered hierarchy, it cannot be classified as comprehensive. Although gender inequality may be present in the United States and The Netherlands – and, indeed, diminishes the practicality of their sexuality education – its exhibition in Uganda is more overt and institutionalized. Ugandan girls may receive biological facts about sex and reproduction, but this knowledge means little in a society where women have very few rights to control their bodies. Women face a dual obstacle when trying to assert autonomy: rejecting a societally-dominant male’s advances and defying the culture of diminished female worth. Condom use is a pivotal step to preventing contraction of HIV/AIDS and relies on equality within a relationship, but in Uganda, females learn to submit to men (Mirembe 291). A girl cannot simply request that her male partner wear a condom because the act of such a suggestion is loaded with challenges to tradition, and places the girl in a precarious situation.

Nyanzi *et al.*’s case study of women in Ugandan marketplaces hypothesized that increasing the economic power of women will increase their autonomy, which will then give them greater power in sexual relationships. These women described their work as empowering precisely because engaging in commerce allowed them to forfeit cultural expectations by becoming equal economic actors with men. The logic manifests as a causal link between economic freedom and the development of social freedom. Women who exhibit independence, confidence, and an ability to challenge men in the marketplace should also be able to display these qualities in sexual relations. However, even these relatively independent women still bowed to expected social norms (Nyanzi *et al.* 20). They were reluctant to suggest that their male partners use condoms because of the “fear of being suspected of infidelity and lack of trust... even admitting knowledge of condoms might arouse suspicions of having learned such techniques from outside partners” (Nyanzi *et al.* 21). To that effect, 61% of the women in the study reported never using one.

The inversion of female cultural status provided by market work, then, is only temporary. Although it provides freedom from cultural expectations, those standards still remain: at work, women were openly insulted by men in the markets for acting masculine, while at home gender relations remained intact (Nyanzi *et al.* 19). Initially, women used the profit from market work for “daily concerns” like transportation, clothing, food and fuel, school fees for their children, hospital bills, and even to buy land or build houses (Nyanzi *et al.* 18). However, their male husbands or partners stopped working or buying things for the family because they knew that the woman of the household had money, thus negating the economic gain by giving men indirect control over where that money was be spent. To combat this entrenched inequality that continually suppresses women, action must be taken earlier. Children must be introduced to accurate information that challenges male superiority so the cycle of female subservience can be stopped.

Structurally, formal adolescent sexuality education has the potential to create a ripple effect on the local level that can improve Uganda's quality of life nationwide. A bonus of school-based adolescent sexuality education "is that school children are expected to pass on information to other members of the family – both children not attending school and adults" (Davies and Mirembe 2). This system would allow the community to benefit from the knowledge of just one student; however, this sexuality education first needs to reach that initial child and must be free from restrictive dogma.

This ideal, however, is impractical because the reality of school-based sexuality education as it stands is inherently flawed. First, not enough kids go to school: formal education is atypical in Ugandan culture, which usually promotes familial education. A critical problem facing the adoption of a national school-based sexuality education system is that "only 43 percent of fifteen-year-olds have completed primary school, and even fewer continue on to secondary school" (Knudsen 42). If less than one third of Uganda's adolescents are affected by the full extent of the formal school system, then it does not represent the best outlet for educating the adolescent population about sex, sexuality, and sexual health.

Second, those kids that do attend school are faced with a school system that "itself may constitute a risk factor in the lives of young people" because various "cultural practices can negate" the education received in class (Davies and Mirembe 1). The Ministry of Education in Uganda creates the national curriculum for HIV education, but restricts it to biological information. The curriculum itself is very "heterosexist" and confined to a "moral framework" that indoctrinates students by teaching that abstinence and the rejection of homosexuality constitute the only viable methods of preventing HIV/AIDS, the biggest sexual health issue facing Uganda (Mirembe 292). Ugandan women are at a much greater risk for STDs and STIs, particularly HIV/AIDS, because of their social inferiority: women between the ages of thirteen and twenty-five face a risk of contracting HIV that is six times higher than men in the same age group (Davies and Mirembe 2). Compounding this risk is the increased drop-out rate for girls, facilitated by cultural practices of using any money available for school on boys (Davies and Mirembe 2). Obbo notes that in some instances, a girl may even feel compelled to engage in sex with an adult male teacher so she can stay in school (Davies and Mirembe 3). The school environment also fosters the gender hierarchy that typifies Ugandan culture by pressuring boys to "conform to masculine ideals of proving manhood" and "reinforcing female helplessness (Davies and Mirembe 13). The school system, then, belittles the seriousness of sexual harassment and homophobia, since each gender is seen as having very defined characteristics that do not admit of deviation (Davies and Mirembe 13). Sex involves a "negotiation process" that denotes equality in a relationship, but this equality does not exist in Uganda (Davies and Mirembe 14). Current expenditures on sexuality education in Uganda meant to empower girls and teach a more comprehensive curriculum are going to waste because the endemic cultural practices are keeping classroom lessons from being applied in real life.

Aside from the gender biases that emerge in Uganda's sexuality education, the actual grading of students in this subject creates friction between the theoretical goal and the reality of teaching. Grading pressures teachers to favor quantity of material over quality of education; they have little incentive to cover AIDS education thoroughly because it does not affect the student's grade as much as other material that must be covered before students are tested (Mirembe 292). As a result, Ugandan students are not learning how to think independently about sex, sexuality, and sexual health, but rather are just receiving facts to learn for an assessment (Mirembe 292).

In addition, Ugandan students cannot trust their teachers to promote sexuality education or autonomy. By perpetuating rumors about condoms and expelling girls who get pregnant, teachers (and even health workers) further alienate adolescents from critical sources of support and information (Kiapi-iwa 344). Teachers do not trust students to be responsible or to act like young adults. Hostile supervision of students blocks this opportunity. If a student claims to be sick, a teacher escorts him or her to the drugstore, preventing the student from purchasing condoms or pills in privacy. Students may attempt to go to the health clinics during school hours so they can avoid seeing peers or relatives. Even if he or she manages to get there, stores usually have low supplies and the cost remains high. Money is one of the most important factors that influence where Ugandan youth seek healthcare services, or whether they do

at all. For example, in Southwest Uganda, the female condom has given women much more control over contraception. But, this relatively new contraceptive device is too expensive for most women in Uganda, negating its immediate usefulness and implementation nation-wide. Students, then, are trapped within an educational system that denies them accurate knowledge, forces them into gender and sexual roles, and severely restricts their ability to acquire the tools with which to be sexually healthy.

It is true that schools incubate adolescents who are straddling youth and adulthood and are the “places where sexual and other identities are developed, practiced and actively produced,” but Ugandan youth are less likely to benefit from such an environment (Davies and Mirembe 3). The current national curriculum is incompatible with the World Health Organization’s standard for sexual literacy. Yet, even if Uganda begins to teach gender equality and sexual empowerment, those messages will be distorted to the point of ineffectiveness if they pass through a sexist and heterosexist culture.

Many youth, then, are left to fend for themselves against STDs, STIs, and pregnancy. Some Ugandan adolescents have sought information from third parties such as churches, media outlets, NGOs, and school groups, but these outlets, too, have failed to significantly improve the state of adolescent sexual health in Uganda. Paralleling the issue in the World Health Organization of funding treatment over prevention, these groups are only responding to the effects of a crippled sexuality education. In almost every aspect of sexuality education, Uganda remains inept; this education needs to be reformed first so that adolescents can remove themselves from the cycle of poor sexual health through knowledge and empowerment. The crux of the problem in Uganda for disseminating the information that spurs knowledge and empowerment resembles the fundamental problem with the World Health Organization’s perspective: the sexuality education approach that has historically worked the best and reached the most students in developed countries (formal education) will not work in Uganda, creating a pressing need for innovation in terms of getting sexual health information to the adolescent population.

Despite the many obstacles facing the formal education system in Uganda, Robina Mirembe (a professor at Kings College Budo in Kampala, Uganda) has identified in her direct work with Ugandan adolescents that schools do have the potential to improve. Mirembe had students at one rural school critique the AIDS curriculum being taught to them. From their responses, she found that “the only reported effect of the curriculum on pupils was a good knowledge of HIV and its transmission,” but not a change in sexual behavior (Mirembe 293). Most of the students felt that the sexuality education curriculum offered in their school benefited the school, their parents, and the government more than their own lives – they “saw the curriculum as irrelevant” (Mirembe 293).

Mirembe spearheaded a reform movement specific to that school, actively getting the students involved in crafting a curriculum based on their needs, desires, and curiosities because they “know their social world best” (Mirembe 294). When students had the ability to direct the education, the program proved more effective: based on their preferences, the students formed groups, heard from professionals, and got a comprehensive curriculum that suited their direct needs. The shift in teaching allowed students to more confidently explore their curiosities. For instance, if the student groups asked the adult to leave the room, he or she allowed the students to form peer groups and learn from one another (Mirembe 299). As a result of this intervention, students learned to “have an open mind before coming to a conclusion,” and many (especially girls) found the new curriculum to be liberating (Mirembe 296-97). Unfortunately, even if reform of the school system offers a more comprehensive sexuality education to adolescents, two problems remain: first, that education will not be accessible to the majority of the adolescent population unless the price of that education is lowered and second, this education cannot be enacted without simultaneous ideological changes in healthcare providers.

The following case study from Adjumani district in Northern Uganda typifies the current issues adolescents face when interacting with healthcare providers. Adjumani is particularly at risk for STDs and STIs, especially HIV/AIDS, because of its geographical location: on the border with Sudan. An environmental factor that leads to contraction of HIV/AIDS is the presence of large movements of people that arise when humanitarian workers pass through Northern Uganda to get to Sudan (Kiapi-iwa 340).

Although young people in Adjumani have been educated about STDs, they remain highly uninformed about their transmission, a factor that greatly increases their risk of acquiring the diseases.

The three main problems with healthcare providers are a lack of anonymity, contraceptive support, and sympathy. Adolescents avoid health centers because of their fear of being seen by relatives in the “very long and highly invisible queues”; even without this factor of visibility, owners will kick-out adolescents who try to buy contraception because they regard adolescence as “a stupid stage” (Kiapi-iwa 341-42). In lieu of formal health centers, Uganda has traditional healers and drug shops. Founded in Ugandan culture, these healers are visited by approximately 80% of Ugandans. They are in such high demand because they know their patients, their patients’ medical histories, and also allow “payments in kind” (Kiapi-iwa 346). They support the use of condoms, but not female birth control, which they are trained to not prescribe: one healer stated that “we [Ugandans] are few, we want people to multiply so why would they [girls] stop producing?” (Kiapi-iwa 343). These figures of traditional authority and culture reject the idea of sex as a pleasurable experience, seeing it instead as strictly a means for procreation.

In general, healthcare providers – both formal and informal – do not believe that young people are able to control themselves sexually. This ageist point of view and abrasive reaction together discourage youth from being sexually responsible. Kiapi-iwa includes several anecdotes from health workers who met with girls in need of abortions, turned them away, and have no clue of their status today. Healthcare center workers were generally “unsympathetic to the needs of young people regarding contraception and pregnancy, and held particularly negative attitudes towards young women when they presented with unwanted pregnancy” (Kiapi-iwa 343). To better serve its adolescent population, Uganda needs to reform health center infrastructure to have improved training, more comprehensive guidelines, and age-specific centers that ensure anonymity (Kiapi-iwa 345). These three changes will allow the adolescent population in Uganda greater flexibility to protect themselves sexually, and will foster a community-wide attitude of support for the sexual health of youth.

One way to begin this change is by capitalizing on the informal system of sexuality education in Uganda, lead by the paternal aunt: the ssenga (Knudsen 42). In the context of sexuality education, they

are expected to play the key role in educating girls from the time of menstruation to marriage about role expectations within marriage in general and sexual roles in particular. Girls are typically taught to have deference to their husbands, to avoid marital conflict by suppressing their anger or disagreement and generally to expect and endure the hardships that come in marriage. They are chiefly responsible for teaching girls how to satisfy their partners sexually, which is considered to be an essential part of being a good wife. Instruction typically includes elongation of the *labia minora* from the time of puberty to enhance male sexual satisfaction, advice never to deny their husbands sex and never to ask for sex directly (Nyanzi 15).

Ssengas set the tone for how girls are expected to behave in sexual relationships and embody a very important potential source for either empowering women in Uganda or keeping them subordinated.

Peer education represents another type of informal education that could prove advantageous for disseminating sexuality education without disrupting Ugandan culture (i.e. through traditionally Western approaches for education). For instance, Robina Mirembe’s case study detailed the success of active peer education among students. Uganda is comprised mostly of rural communities that are more stable than urban areas, and which consequently present greater opportunities for strong community engagement (Nakibinge 193).

Tapping into and coordinating these natural resources on a grand scale will require the assistance of international organizations, which have the capacity to provide personnel, financial, and educational assistance. Nakibinge’s study of a twenty-year community outreach program in a rural Ugandan community highlights the need for involvement of the whole community, the benefits of continuity, and the importance of finances in improving sexual health.

Uganda's Trans-African Highway runs nearby the village in the study and brings "commercial sex and transmission of HIV and other sexually transmitted infections in its wake" (Nakibinge 191). This region of Uganda is marked by farming, low literacy, and lack of formal roads and mass communication other than "local radio" (Nakibinge 191). As a result, the study had to rely on more informal, community-based methods of health promotion to educate the community about sexual health.

Leaders engaged the population through community meetings, which created a "feedback system for identifying problems... generating solutions... and reporting back on implementation of these solutions" (Nakibinge 192). Informal leaders within the community were purposefully asked to be involved in the study so that the community would be more accepting of the presence of the researchers conducting the study (Nakibinge 192). Fourteen teachers were trained to be part of a program aimed at primary and secondary students (and their out-of-school counterparts); parents were educated about the program beforehand and were assured that the material used was age-appropriate (Nakibinge 193). Ssengas and the *koja* (the paternal uncle who educates boys about sex) were identified as vital educational sources, and researchers worked to improve the quality and accuracy of their sexuality education (Nakibinge 193). The research group also deconstructed stigma associated with HIV/AIDS through the formation of an educational group of 20 people living with these diseases who discussed their HIV status, promoted the use of anti-retroviral treatment, and provided peer support (Nakibinge 193). The overarching goal of the program was to open lines of communication within the community in order to encourage active discussion of matters related to sexual health.

One of the atypical benefits offered by this study was free condoms for the villagers (Nakibinge 193). Although this factor undoubtedly helped prevent the spread of STDs and STIs and reduced unintended pregnancies, it also skews the results because condoms are not as readily available in other Ugandan communities.

The most striking result of the study was the increase in knowledge of HIV status in the community: "the proportion of men who know their HIV status has increased from 6% to 25%, and the proportion of women from 5% to 34%, over the past 5 years" (Nakibinge 193). While the numerical increase may seem small, the improvement is nonetheless important and shows the positive effects of sustained community outreach in Uganda on sexual health.

Our Call to Action

The World Health Organization acknowledges a contemporary "paradigm shift in sexual health and education, from one of population control to a 'rights' framework, and warns" that distancing young people from knowledge about sex, sexuality, and sexual health will reap dangerous results (Goldman 419). The consequences are explicit: adolescents "who learn a repressed, evasive and dishonest representation of biological facts and sexual language... grow into ignorant, embarrassed and inarticulate adults" (Goldman 432). Youth transitioning physically from childhood to adulthood are not being equipped intellectually with the knowledge and skills to function as empowered adults. Once physically developed, they remain devoid of knowledge of the realities of sex, sexuality, and sexual health. Abstinence-only education definitively fails to meet the World Health Organization's standard for sexual health. This corrupted educational method positions adolescents with minimal resources to defend themselves from STDs, STIs, unwanted pregnancy, sexual coercion, and without the capacity to be confident sexual actors. Only comprehensive sexuality education instills adolescents with the knowledge of sex, sexuality, sexual health that enables them to achieve a high degree of sexual literacy that in turn leads to their actualizing the WHO's standard for sexual health.

Today, almost half of all girls will start puberty at age 10, while the same number of boys will begin puberty around age 11 (Goldman 425). Girls will typically have their first period at age 12 and boys will experience their first ejaculation at age 13 (Goldman 425-26). Sexuality education classes, for the most part, are not starting soon enough for adolescents who begin puberty younger, leaving them in a critical state of doubt, anxiety, and ignorance. These mental states only endanger the sexual health of

adolescents. The facts are clear: there is a quantifiable need to start sexuality-education in primary school if curricula are to have any significant impact on the most youth.

Statistically, youth are suffering because of the inability of parents, school boards, and governments to acknowledge that adolescents can and do have sex, and that they need help to help themselves. At this moment, “exactly one half of the world’s adolescent births occur in seven countries alone: Bangladesh, Brazil, the Democratic Republic of the Congo, Ethiopia, India, Nigeria, and the United States” (WHO Adolescent Fertility Rates 1). It is important to note that adolescent girls are more likely to have unintended pregnancies and that these pregnancies are more likely to end in self-inflicted abortions; the rates of both are increased by “coerced sex, reported by 10% of girls who first had sex before age 15 (WHO Adolescent Fertility Rates 1). Adolescents are also more vulnerable to complications arising from abortions and “fourteen percent of all unsafe abortions in low- and middle-income countries are among women aged 15-19 years,” which is equivalent to about 2.5 million adolescents (WHO Adolescent Fertility Rates 1). Many of these girls are forced to seek back-door abortions because of cultural stigma or fear, even in the United States. As a world leader in science, medicine, and health, the United States should not be on these lists, but in reality, it deserves to because its sexuality education is on par with the Third World.

The Netherlands exhibits the effectiveness of sexuality education reform on a national level, and this progressive attitude has yielded positive results in the form of improved adolescent sexual health and knowledge. The Netherlands’ comprehensive sexuality education model empowers youth to be responsible for their sexual health, and supplies them not only with knowledge about sexuality in schools, but also enhances that learning within the framework of a culture that advocates for good adolescent sexual health. The government accepts that some adolescents are sexually-active and works to provide them with thorough information that will enable positive sexual health. The core message in The Netherlands is one of trust and informed autonomy.

Meanwhile, rather than embrace scientific and educational progress, the United States has fallen prey to the politically-entrenched fundamentalist Christian vision for America and has regressed as a result. The federal government endorses abstinence-only education, despite the fact that it promotes a closed-minded view of sexuality that fails to improve the sexual health and preparedness of adolescents. The non-mandatory status of sexuality education in the U.S. destabilizes the sexuality education infrastructure further, granting local influences (county governments, school boards, Parent Teacher Associations, etc.) too much power over the content of the curriculum. As a result, only 14% of U.S. school districts have comprehensive sexuality education programs and, statistically, teenagers in the United States have worse sexual health in terms of rates of STDs, STIs, teenage pregnancies, and abortions than nearly every other developed nation in the world.

Uganda also institutionalizes moral beliefs through schools systems, though to a greater degree than the United States. Ugandan culture shuns adolescent sexuality and reinforces the stigma against birth control and homosexuality. Health workers and clinics chastise youth who try to protect themselves from STDs, STIs, and unwanted pregnancies through avenues other than abstinence. The sexist, homophobic culture subordinates girls and reinforces traditional gender roles, making sexuality education useless for them. Traditional healers in Uganda are the most popular form of healthcare, in part because they have roots in the local culture and know their patients better; as such, they represent a source for initiating reform of Uganda’s sexuality education.

Adolescents around the globe deserve to be trusted, addressed as young adults, taught a comprehensive curriculum that meets their needs, and given the knowledge that they have a right to receive. Silence breeds ignorance, and for many adolescents, ignorance can mean the difference between life and death. It is our duty to ensure that we support truth and knowledge about the human body. The World Health Organization has provided a standard for the nations of the world to aspire to meet:

Sexual health is “a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive

and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (Herdt and Howe 89).

“All persons” includes adolescents. The next generation is counting on us to recognize that this definition is not just a compilation of lofty goals and dreams, but a transnational call to action.

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Research Strategy

The beginning of the research strategy entailed entering key phases into the Goucher College Library online databases, particularly EBSCO and JSTOR. The online databases provided a medium for specified research that would yield rapid results and allow for easy alterations to key words, subjects, questions, or phrases as the research unfolded. I first manipulated the basic concepts of “sex education,” “sexuality education,” and “sexual health” paired with “the United States,” “The Netherlands,” and “Uganda.” I found that the designation of a word or phrase as a “subject,” “title,” “key word,” or “appearance in the text” greatly impacted the quantity of results a search produced.

Both the breadth and lack of results proved frustrating at times, and the process could become quite tedious. However, the more time I spent with the search engines the more astute I became at working with the system and tailoring my questions to fit the breakdowns presented by EBSCO and JSTOR. The in-person resources helped facilitate a launching pad for further research at the beginning of the process. A research consultation with Randy Smith afforded me three articles and two books that pertained to my topic. Having assistance with acquiring the initial sources for my paper reduced the anxiety about finding where to begin looking for information.

Later, the library book catalog very quickly located more detailed and lengthier volumes to apply to my topic. Even if the specific books I searched were lost within the shelves, the general vicinity the catalog led me to proved worth the effort. Likewise, the Interlibrary Loan system plugged-in any holes that the Goucher library could not immediately fill. All it required was a bit of patience to wait for a book or journal article, during which time I could continue to peruse the online databases for more information.

As a freshman writing my first extensive research paper, I felt incredibly motivated but also daunted by the task of finding the research. Despite my excitement at the process of synthesizing information into a powerful statement, I knew that I first had to find that information. The Goucher College Library resources – principally the online journal databases – made the research process easy to navigate and conducive to the evolution of my research question.